U.S. Department of Health and Human Services
Office of the Assistant Secretary for Preparedness and Response
Office of Operations and Resources
Emergency Management and Medical Operations
Division of Readiness
National Healthcare Preparedness Programs Branch

Notice of Funding Opportunity and Grant Application Instructions

Funding Opportunity Title:
Partnership for Disaster Health Response Cooperative Agreement
CFDA# 93.817

Funding Opportunity Number: EP-HIT-21-003
Application Due Date: September 20, 2021

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Announcement Type: Cooperative Agreement

Funding Opportunity Number: EP-HIT-21-003

Catalog of Federal Domestic Assistance (CFDA) Number: 93.817

All applications must be submitted by: September 20, 2021 at 11:59 PM ET.

I. FUNDING OPPORTUNITY DESCRIPTION

Statutory Authority

Section 319C-2 of the Public Health Service (PHS) Act (42 U.S.C. § 247d-3b), as amended

BACKGROUND:

Government Agency

The Office of the Assistant Secretary for Preparedness and Response (ASPR) is a staff division within the Office of the Secretary, U.S. Department of Health and Human Services (HHS). ASPR leads the nation's efforts to protect Americans from health security threats, providing unity of command in responding to and recovering from disasters and health security incidents. ASPR focuses on preparedness planning and response; federal emergency medical operational capabilities; countermeasures research, advance development, and procurement; and grants to strengthen the capabilities of hospitals and health care systems to prepare for, respond to, and recover from public health emergencies and medical disasters. ASPR also provides federal support, including medical professionals through its National Disaster Medical System, to augment state and local capabilities during an incident.

Executive Summary

When disaster strikes, communities need their health care system to be ready to respond. However, previous large-scale disasters and the ongoing COVID-19 pandemic demonstrate that even the most prepared communities struggle to effectively deliver health care services in times of crisis. To address gaps in health care delivery during disasters, ASPR developed a Regional Disaster Health Response System (RDHRS). The RDHRS is a tiered system that builds upon and unifies existing assets within states and across regions that supports a more coherent, comprehensive, and capable health care disaster response system able to respond health security threats. The RDHRS integrates clinical and health care systems' operational expertise into existing preparedness and response structures at the local, state, and regional level, and expands capabilities and capacity for improving disaster readiness across the health care system, increasing medical surge capacity, and providing specialty care - including trauma, burn and infectious disease, among others - during large-scale disasters or public health emergencies. RDHRS sites build on existing medical surge and disaster preparedness foundations across industry and government, fostering and mature multi-state partnerships as well as industry assets to create an integrated, tiered system of disaster health care.

The RDHRS is designed to complement existing Medical Surge Capacity and Capability (MSCC)[1,2] foundation for local or sub-state medical response (e.g., trauma systems and health care coalitions (HCCs)) by enhancing coordination mechanisms and incorporating discrete clinical and administrative capabilities at the state and regional levels. The HCCs serve as partnerships between core member stakeholders in health care, emergency medical services (EMS), public health, and emergency management. These coalitions are focused on facilitating an integrated and coordinated response across the local area.[3] The RDHRS complements these local efforts through statewide and regional surge capacity building, situational awareness, readiness metric development, and capability testing exercises, among other regional efforts. While the RDHRS operates at a regional level to enhance health care disaster preparedness and response, the RDHRS is not intended to alter or displace current local patient referral patterns. It is instead intended to define the delivery of clinical care when the existing referral patterns and health care delivery capacity and capabilities are exceeded by catastrophic events (requiring either redistribution of patients, importation of resources, or resource utilization guidelines).

While significant progress has been made in many health care preparedness and response capability areas, there is still much work to be done. In particular, the medical aspects of disaster response, especially those related to the promotion and sharing of strategic medical intelligence, clinical expertise, and complex medical management have not been as well addressed, nor have issues of patient care coordination across larger geographic areas. This includes assuring that clinical expertise is available during specialized responses (e.g., radiation response), and is integrated into decisions about response assets, crisis standards of care, and administration of medical countermeasures (e.g., large-scale administration of intravenous anthrax countermeasures).

Health care is almost exclusively a private sector function but holds public responsibilities during a disaster. Health care system capacity is stretched thin on a daily basis, and the specific challenges of planning for a large-scale event involving critical care, burn care, pediatric care, high consequence infectious diseases, or radiation exposure require rapid engagement of subject matter experts into decision-making and a robust understanding and leveraging of area resources. HCCs, funded through the annual Hospital Preparedness Program (HPP) cooperative agreement, play a critical role in developing health care delivery system preparedness and response capabilities among their members at the local level. However, when it comes to multiple coalitions or multiple states, additional coordination at the regional level is necessary to generate access to specialized clinical expertise, situational awareness, and patient movement across those jurisdictions.

ASPR aims to better identify and address gaps in coordinated patient care during disasters through the establishment and maturation of a Regional Disaster Health Response System (RDHRS) (**Figure 1**). The primary objectives of the RDHRS are to:

1. Improve bidirectional communication and situational awareness of the medical needs and issues of

[1] Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies. https://www.phe.gov/Preparedness/planning/mscc/handbook/Documents/mscc080626.pdf
[2] MSCC: The Healthcare Coalition in Emergency Response and Recovery. https://www.phe.gov/Preparedness/planning/mscc/healthcarecoalition/Pages/default.aspx

[3] 2017-2022 Health Care Preparedness and Response Capabilities. Office of the Assistant Secretary for Preparedness and Response. November 2016. http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capablities.pdf.

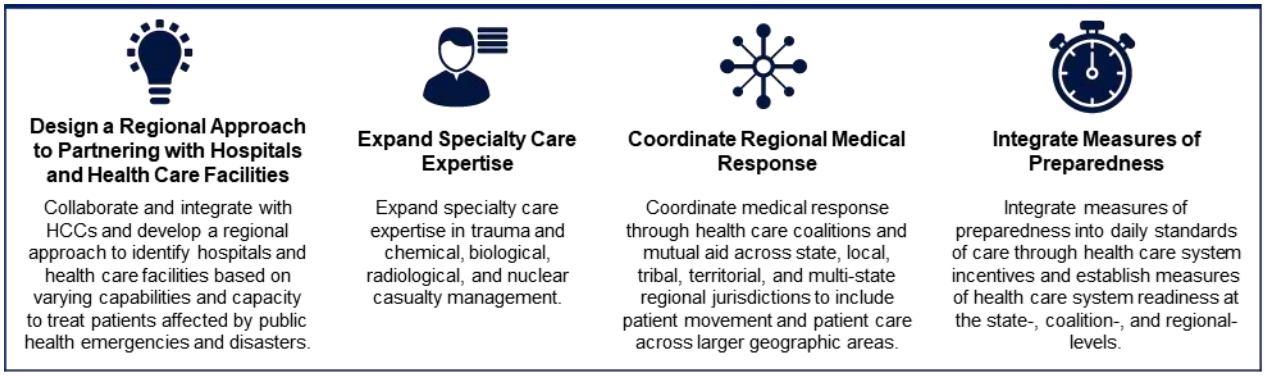
the response between health care organizations and local, state, regional, and federal partners;

2. Leverage, build, or augment the highly specialized clinical capabilities critical to unusual hazards or catastrophic events; and

3. Augment the horizontal (whole of community) and vertical integration of key stakeholders that comprise health care coalitions with readily accessible and clinical capabilities that are largely missing from the current configuration of such coalitions.

At all levels of RDHRS, activities aim to optimize clinical surge capacity, provide clinical expertise to support health care surge planning, and ensure that appropriate clinical expertise is involved and empowered as a partner in emergency planning and response. At the state level, RDHRS specifically aims to establish more robust situational awareness of health care system capability and capacity, coordination and prioritization mechanisms for patient transfers, process and policy for resource management, and access to clinical specialists in areas such as pediatrics, trauma and burn care, and infectious disease. The maturation of these capabilities will better enable states to respond to health care crises within and across their geographic boundaries as well as increase their ability to support resource requests from other states. At the regional (e.g., multi-state) level, the RDHRS will cultivate and establish mechanisms for sharing the clinical expertise necessary to respond to large scale disasters and high-risk threats (e.g., chemical, biological, radiological, and nuclear (CBRN) threats) and provide a mechanism to coordinate patient care and movement across jurisdictional boundaries. RDHRS will also integrate with and leverage the expertise and resources of existing response systems including trauma systems as well as specialty systems for biologic (e.g., National Emerging Special Pathogens Training and Education Center) and radiologic hazards (e.g., Radiation Injury Treatment Network).

Figure 1. Objectives of the Regional Disaster Health Response System



This Notice of Funding Opportunity (NOFO) does not aim to establish the nationwide RDHRS in its entirety, but instead seeks to fund a demonstration site that will advance the vision for a nationwide, regional response system, and that will help identify issues, develop leading practices, and demonstrate the potential effectiveness and viability of this concept. The new award will focus primarily on building and maturing the partnerships that are required to effectively prepare for and respond to the management of patients in disasters, including those that facilitate rapid expansion of medical surge capacity of the existing health care system, coordination of patient and resource movement to support the response, and the swift involvement of specific clinical specialists, building on lessons learned from the three active demonstration sites established in 2018 and 2020. The intent of this effort is to enhance response capabilities for both

small- and large-scale emergencies and disasters. Whereas the health care coalition effort has successfully promoted "horizontal integration" of key stakeholders in the emergency response system, including health care entities and organizations, this effort will bolster such efforts by simultaneously promoting "vertical integration" of key expert resources such as trauma centers, pediatric centers, and poison control centers.

ASPR currently funds cooperative agreements serving as demonstration sites in preparation for building a full nationwide system with RDHRS sites in every region. Current sites include the Region 1 Regional Disaster Health Response System based at Massachusetts General Hospital, Region VII (7) Regional Disaster Health Ecosystem (RDHRE) based at University of Nebraska Medicine, and the Mountain Plains RDHRS in Region 8 based at Denver Health and Hospital Authority. The demonstration sites in Region 1 and Region 7 were initiated in FY 2018, whereas the Region 8 site was initiated in FY 2020. These sites demonstrate the capabilities of a RDHRS for enhancing preparedness and response coordination at a regional level, identify leading practices and lessons learned for future RDHRS sites. Thus far, the existing demonstration sites have produced over 50 tools and products to support training, organization and reporting structure, data collection and information sharing, telemedicine, state deployable medical teams (DMT), and navigating legal and policy challenges.

The existing demonstration sites have already shown impact and potential for return on investment. The Region 1 RDHRS conducted a survey and found that 89 percent of surveyed participants agreed that RDHRS is addressing gaps within disaster health care preparedness and response that have not yet been addressed.[4] Additionally, 93 percent of Region 1 RDHRS participants surveyed agreed that the RDHRS can be an effective resource to provide medical expertise to public health and/or emergency management leaders to assist with decision-making related to health care operations during disasters. The sites have additionally demonstrated clear impact through preparedness and response efforts in their regions. For example, both Region 1 and 7 have enhanced regional operationalization through both actualized and potential models for state- or hospital-hosted deployable medical teams including strategies for creation and long-term sustainability to enhance regional capacity especially in the first 72 hours of response. Additionally, the demonstration sites generated frameworks for the essential elements of information (EEI) necessary to facilitate medical surge response at the statewide and multi-state regional levels and a roadmap to create an interoperable information technology (IT) system for collecting and sharing EEI and other real-time situational awareness. Additionally, the demonstration sites created recommendations for readiness metrics that can be used for peer review assessments, monitoring, recognition reporting, and a "Response Ready" designation program for HCCs. The Mountain Plains RDHRS in Region 8, currently in its first year, continues to expand the RDHRS model and vision for multi-state, regional emergency preparedness and response partnerships. To date, the Mountain Plains RDHRS is focused on identifying and onboarding key partners, developing the partnership, and responding to both COVID-19 and other disasters including wildfires.

Together, each of these programs advances work not only within the demonstration site and region, but also has the potential to impact programs and policies on a nationwide scale. More information about the progress of the initial two RDHRS demonstration projects during year one can be found in a Report to Congress, which was released in July 2020, with additional information available on phe.gov. Additional examples of recent key accomplishments from the RDHRS sites in Region 1 and Region 7 can be found in the MA/Region1 RDHRS 2020 Annual Report and the Region VII Disaster Health Response Ecosystem 2020 Annual Report.

ASPR will fund one (1) new "Partnership" that will serve as a demonstration site for implementation of the RDHRS concept. The Partnership will bring together required members as described in the Eligibility Criteria section and as required by section 319C-2(b)(1)(A)[5] of the Public Health Service

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[5] Be a coalition that includes—(i) one or more hospitals, at least one of which shall be a designated trauma center, consistent with section 1213(c) of the PHS Act;(ii) one or more other local health care facilities, including clinics, health centers, community health centers, primary care facilities, mental health centers, mobile medical assets, or nursing homes; (iii) (I) one or more political subdivisions; (II) one or more states; or (III) one or more states

Act (42U.S.C. § 247d-3b(b)(1)(A)), as amended. Successful applicants will propose a governance structure that is capable of coordinating health care assets across the recipient's state and is also poised to share information and medical assets with other states in their HHS region.

ASPR designed the capabilities included in this NOFO to be complementary to the Health Care Preparedness and Response capabilities but emphasize the clinical coordination aspects of disaster response. These are discussed in detail below and include:

- Building a Partnership for Disaster Health Response;
- Aligning Plans, Policies, Processes, and Procedures Related to Clinical Excellence in Disasters;
- Increasing Statewide and Regional Medical Surge Capacity;
- Improving Statewide and Regional Situational Awareness; and
- Developing Readiness Metrics and Conduct an Exercise to Test Capabilities.

Purpose

To fund one demonstration project that will help identify issues, develop leading practices, and demonstrate the potential effectiveness and viability of the RDHRS concept. The RDHRS structure is conceptualized as a tiered system that builds upon the existing Medical Surge Capacity and Capability (MSCC)[6,7] foundation for local medical response (e.g., trauma systems and HCCs) by enhancing coordination mechanisms and incorporating discrete clinical and administrative capabilities at the state and regional levels. The RDHRS is not intended to alter or displace current local patient referral patterns, but is instead intended to define the delivery of clinical care when the existing referral patterns and health care delivery capacity and capabilities are exceeded by catastrophic events (requiring either redistribution of patients, importation of resources, or resource utilization guidelines). Additionally, the RDHRS is intended to provide additional health care integration and expertise into preparedness and response structures.

Project Outcomes

- The recipient will establish a regional Partnership of health care and governmental partners relevant to the coordinated delivery of patient care in disasters, as described in the "Capability 1: Build a Partnership for Disaster Health Response" section below. The recipient is encouraged to begin with statewide structures to build a strong foundation for further expansion into the region.
- The Partnership will operationalize the capabilities necessary for effective and coordinated

and one or more political subdivisions; and (iv) one or more emergency medical service organizations or emergency management organizations.
[6] Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies. https://www.phe.gov/Preparedness/planning/mscc/handbook/Documents/mscc080626.pdf
[7] MSCC: The Healthcare Coalition in Emergency Response and Recovery. https://www.phe.gov/Preparedness/planning/mscc/healthcarecoalition/Pages/default.aspx

emergency response to identify leading practices, lessons learned, and barriers to state- and region-wide implementation and coordination of the RDHRS concept, as described in the sections titled "Capability 2: Align Plans, Policies, Processes, and Procedures Related to Clinical Excellence in Disasters," "Capability 3: Increase Statewide and Regional Medical Surge Capacity," and "Capability 4: Improve Statewide and Regional Situational Awareness."

- The Partnership will test, refine, and add to previously developed draft RDHRS readiness metrics related to the operational capabilities described in "Capability 2: Align Plans, Policies, Processes, and Procedures Related to Clinical Excellence in Disasters," "Capability 3: Increase Statewide and Regional Medical Surge Capacity," and "Capability 4: Improve Statewide and Regional Situational Awareness."

- The Partnership will conduct a state- or region-wide exercise to test the operationalization of these capabilities as described in detail in the section titled "Capability 5: Develop Readiness Metrics and Conduct an Exercise to Test Capabilities."

Implementation

Strategy: The partnership will demonstrate the following capabilities in support of a coordinated, statewide and regional emergency response. The recipient must address all components included in the "objectives" and "activities" listed below in their application. The recipient is encouraged to work with partners, such as statewide and regional HCCs, to prioritize objectives and activities based on regional needs.

Capability 1: Build a Partnership for Disaster Health Response

Objective 1: Establish and Build a Partnership for Disaster Health Response

Activity 1: Identify partnership members and build the necessary relationships to facilitate statewide coordination of health and medical assets in disaster planning and response.

- Partnerships must include the following required members:
    - One or more hospitals, at least one of which shall be a designated trauma center;[8, 9]
    - One or more other local health care facilities, including clinics, health centers, community health centers, primary care facilities, mental health centers, mobile medical assets, or long-term care facilities; and
    - One or more political subdivisions, one or more states, or one or more states and one or

[8] For states that do not have trauma centers, partnerships may include trauma centers in neighboring states that are willing to become partners. The application must clearly demonstrate how funds will be shared with the trauma center despite the fact it is in different state from the partnership. The American College of Surgeons sets the standards for trauma center designation. These standards/processes are found at http://www.facs.org/trauma/ntdbacst.html. Simply put, a trauma center (TC) is designated in one of two ways: (1) TC directly contacts the American College of Surgeons (ACS) Verification Program or (2) the state has passed laws for its own designation process and the designations are done at the state level. In this latter case, states must use the same standards as required by the ACS's verification program.
[9] ASPR strongly encourages partnerships to include an ACS/COT designated level 1 trauma center.

more political subdivisions; and

- One or more emergency medical service organizations or emergency management organizations.

- A signed memorandum of agreement (MOA) or memorandum of understanding (MOU) must be submitted by each required member of the partnership as an appendix in the application package.

- Partnerships must also acquire and submit letters of support from, at a minimum, the following supporting organizations:

  - State Office of Public Health/Health
  - Health care coalition leaders (or points of contact) in the state
  - State Trauma Advisory Council (or equivalent)
  - State Office of Emergency Medical Services

- Describe any existing relationships with the additional partners listed in the special requirements section, and, where possible, submit letters of support from these entities.

- Identify operational barriers to accomplishing the project outcomes and how these barriers will be overcome. Prioritize building relationships with organizations which focus on the needs of at-risk patients and integrating health equity into disaster health planning and response.[10,11]

Activity 2: Propose and implement a governance structure for the partnership that enables performance of the requisite capabilities, objectives, and activities.

- Propose and implement an overall governance structure for the partnership, including the roles and responsibilities of all participating entities and organizations.

- Designate an Executive Director and a Medical Director to act as leaders of clinical preparedness and response and neutral brokers among the partnership members and supporting

[10] This document uses the term "at risk individuals" broadly, recognizing that this term encompasses a vast range of people and experiences, and fluidly, recognizing that each unique emergency or disaster may have different impacts on different individuals and groups. For example, at-risk individuals may include (but are not limited to) those "at higher risk for health disparities by virtue of their race or ethnicity, socio-economic status, geography, gender, age, disability status, or other risk factors including those associated with sex and gender" (*HRSA 2019-2022 Strategic Plan*); children, older adults, and pregnant women (as specified by the Public Health Service Act); individuals with access or functional needs, who live in institutionalized settings, are from diverse cultures, who have limited English proficiency or are non-English speaking, who are transportation disadvantaged, who have chronic or complex medical conditions (ASPR – At Risk Individuals); and many others. PAHPAI recognizes "at risk individuals" as people with access and functional needs that may interfere with their ability to access or receive medical care before, during, or after a disaster or emergency. Irrespective of specific diagnosis, status, or label, the terms, access-based needs are all people must have access to certain resources, such as social services, accommodations, information, transportation, medications to maintain health, and so on. Function-based needs refer to restrictions or limitations an individual may have that requires assistance before, during, and/or after a disaster or public health emergency.

[11] Health equity, as defined by the Health Resources & Services Administration (HRSA) – Office of Health Equity, is the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographic areas in health status and health outcomes such as disease, disability, or mortality.

organizations.[12]

- Describe and implement integration of the partnership with existing state and community incident management structures and specify roles within the partnership that augment and complement existing systems and processes.

- Describe and implement plans to convene partnership members at least quarterly.

- Identify and document governance leading practices.

Activity 3: Identify and build mechanisms that enable the partnership to coordinate with equivalent entities in other states in their HHS region.

- Describe any established or potential relationships, processes, and mechanisms that would allow for information, material, personnel, and expertise to be shared across states in an emergency.

- Identify mechanisms to engage in regional planning, share protocols and leading practices, and participate in exercises with other states.

- Identify and document challenges related to working with other state partners.

Capability 2: Align Plans, Policies, Processes, and Procedures Related to Clinical Excellence in Disasters

Objective 1: Identify and Address Critical Clinical Capabilities and Gaps in Existing Disaster Plans

Activity 1: Assess statewide risk and vulnerabilities related to the clinical management of patients.

- Demonstrate partnership involvement in state and local disaster planning efforts to ensure clinical accuracy and relevance while drafting and updating disaster plans.

- Include trauma systems in state disaster planning processes. Determine the clinical impact of likely disaster response scenarios with attention to demands on the health care system that would overwhelm existing local and regional capability and capacity.

- Identify and document regional and statewide health care resources and services that are vital to continuity of health care delivery during a disaster (e.g., clinical services, infrastructure, supply chain, caches, health care workforce, etc.).

Activity 2: Identify and document planning gaps related to clinical surge capacity, addressing those gaps where possible.

- Identify and document potential gaps in state and regional surge capacity planning for conventional, contingency, and crisis surge – accounting for the needs of at-risk populations.[13]

[12] Grant funds may be used to pay a salary for each of these positions.

[13] Hick JL, Barbera JA, Kelen GD. Refining surge capacity: Conventional, contingency, and crisis capacity. Disaster Med Public Health Prep.

- Identify and document surge capacity assets in the state and region required for a clinical response to high consequence infectious disease, burn, pediatric, and mass casualty scenarios, as well as any scenario identified in Activity 1 that is significantly likely to overwhelm existing capability and capacity.

- Conduct a statewide needs assessment of the implementation of an alternate care system, including telehealth (e.g., alternate care site locations, required technology, personnel, supplies, equipment)[14, 15] and the means by which such systems would complement the conventional delivery of health care services (e.g., telemedicine, electronic prescribing, triage lines).

- Define the indicators and triggers needed to initiate crisis standards of care.[16]

- Identify barriers and gaps related to the use of conventional, contingency, and crisis care strategies.[17]

- Where state crisis standards of care plans have been developed, ensure there is an implementation plan for crisis care in the clinical setting.[18]

Objective 2: Align Existing Coalition and State Response Plans to Facilitate Coordinated Medical Surge

Activity 1: Build a framework for the coordination of planning activities related to the management of patients in disasters across all RDHRS tiers (i.e., coalition-, state-, and regional-levels).

- Develop consistency of protocols, policies, and procedures across coalitions (to the degree possible).

- Identify and resolve potential conflicts related to coordination of health care assets (e.g., patient movement, patient tracking, expertise and resource sharing, and policy support) across multiple coalitions.

Objective 3: Facilitate Legal and Policy Coordination and Alignment

Activity 1: Identify laws, regulations, and policies that impact the establishment of statewide and regional

2009;3(2 Suppl):S59–S67.

[14] Institute of Medicine. (2012). Crisis Standards of Care. A Systems Framework for Catastrophic Disaster Response. Volume 5: Alternate Care Systems.

[15] Alternate Care Systems: Stratification of Care. Hanfling D. (2009). https://www.ncbi.nlm.nih.gov/books/NBK32849/

[16] Hanfling D, Hick JL, Stroud C, eds; Committee on Crisis Standards of Care. Crisis Standards of Care: A Toolkit for Indicators and Triggers. Washington, DC: The National Academies Press; 2013.

[17] Hick JL, Barbera JA, Kelen GD. Refining surge capacity: Conventional, contingency, and crisis capacity. Disaster Med Public Health Prep. 2009;3 (2 Suppl): S59–S67.

[18] Non -Discrimination Requirements: If you receive an award under this announcement, you must not discriminate on the basis of race, color, national origin, disability, age, and in some cases sex and religion. You must ensure your contractors and sub -recipients also comply with federal civil rights laws. Civil Rights are not suspended or waived in the times of disaster, including COVID -19. The HHS Office for Civil Rights (OCR) enforces federal civil rights laws, including Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act which prohibit discrimination on the basis of disability in HHS funded health programs or activities. These laws, like other civil rights statutes that OCR enforces, remain in effect. The HHS OCR provides guidance to recipients in complying with civil rights laws that prohibit discrimination on its OCR webpage. HHS provides guidance to recipients of federal financial assistance on meeting the legal obligation to take reasonable steps to provide meaningful access to persons with limited English proficiency. See Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311, 47313, HHS OCR 2003, or on the HHS OCR guidance webpage. For guidance and technical resources on Crisis Standards of Care, please see ASPR TRACIE's resource page.

(i.e., multi-state) coordination of health care in disaster planning and response.

- Document the state processes for declaration of emergencies, specific state-level waivers that may be implemented, existing liability protections for health care providers in disasters, and laws and regulations related to allocation of personnel, resources, telehealth, and equipment.

- Document the state-level legalities surrounding alternate care systems (e.g., alternate care sites, crisis standards of care, quarantine and isolation).

- Document existing laws, regulations, and policies that impact interstate (i.e., regional) coordination of health care assets, including the sharing of highly specialized clinical expertise, in large-scale disasters, patient transfers across state lines, liability protections for health care providers in disasters, and laws and regulations related to allocation of personnel, resources, telehealth, and equipment.

Activity 2: Establish a mechanism for real-time legal, regulatory, and policy discussion related to the coordination of patient care in disasters.

- Demonstrate a process for joint clinical policy development during a disaster (e.g., establishment of common clinical guidelines, crisis standards of care, fatalities management, etc.).

Capability 3: Increase Statewide and Regional Medical Surge Capacity

Objective 1: Train and Prepare the Health Care and Medical Workforce

Activity 1: Educate and train the health care and medical workforce on identified preparedness and response gaps related to the clinical management of patients.

- Identify basic elements to be included in a standardized training program for medical response personnel (e.g., state-sponsored medical teams), health care providers, and medical volunteers. This might include disaster ethics, workforce resilience and behavioral health, triage principles, health equity and considerations for at-risk individuals, assessment and care of injuries or illness resulting from known CBRN threats, and other topics.

- Conduct a gap analysis of required and available training at the state and local levels for clinical response personnel who would detect or respond to a CBRN emergency. Consider training related to health care worker protection, responder safety and security, individual resilience, HAZMAT, and infection control, especially as related to pathogens of high consequence.

- Demonstrate how just in time (JIT) training may be provided to increase health care worker resilience as required for response to different hazards and by professionals of different clinical specialty expertise.

Activity 2: Identify and develop the clinical expertise needed to support medical surge in large-scale and highly specialized disaster scenarios.

- Provide specialized surge management, expertise, education, and patient care coordination (to include EMS capabilities) during emergencies that result in a surge of (1) chemical, (2) radiation, (3) burn, (4) trauma, (5) high consequence infectious disease, and/or (6) pediatric patients, including, considerations for individuals who may be at increased risk during disaster.

- Assess needs and provide behavioral health support during a response.

- Identify methods to disseminate existing response expertise (e.g., NETEC, Radiation Injury Treatment Network, trauma, etc.) in the state and deploy through means such as telemedicine and mobile teams to support medical surge in large-scale and highly specialized disaster scenarios.

- Conduct a statewide analysis of medical countermeasures and personal protective equipment (PPE) acquisition and distribution strategies that will be undertaken in health care settings (e.g., retail pharmacies, clinics, hospitals, long-term care, etc.) or that are likely to require clinical staffing (e.g., home delivery, points of distribution, etc.) and identify challenges in administration, provider training, and facility capacity.

Objective 2: Identify and Utilize Health Care Surge Professionals

Activity 1: Draft a plan for the use of health care surge professionals internal and external to the state.

- Develop a model and plan for the establishment, deployment, and sustainment of specialized medical teams to large-scale disasters that occur within and outside of the state.

- Ensure that highly specialized clinical capabilities in infectious disease, pediatrics, and trauma and burn care are readily available anywhere in the state during large-scale disasters.

- Plan for the use of health care volunteers to support statewide medical response efforts.

- Implement mechanisms to use appropriately licensed health professionals from states within and outside of the HHS region during disasters (e.g., Uniform Emergency Volunteer Health Practitioners Act, central credentialing process, centralized request for hospital staff).

- Develop a model and plan for the deployment of Medical Reserve Corps (MRC) and Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) volunteers and define how these assets may be used to support medical surge planning and response within and outside of the state.

- Plan for the use of unaffiliated health care providers (e.g., licensing and credentialing agreements) to support statewide medical response efforts.

- Demonstrate knowledge of available interstate medical resources and personnel (e.g., Emergency Management Assistance Compact (EMAC), etc.) so that they may be rapidly shared across state lines.

- Plan for addressing workforce resilience and behavioral health needs of health care providers

and volunteers.

Objective 3: Increase Readiness for Medical Surge

Activity 1: Improve inpatient, hospital, and EMS surge response.

- Draft policies and procedures that enable statewide visualization of emergency department (ED) and inpatient medical surge capacity using the mechanism described in Capability 4, Objective 1. Ideally these metrics should be reported through electronic health records systems and not manually.

- Promote implementation of surge capacity planning efforts in the management of seasonal and other ED overcrowding issues, including COVID-19 surge planning.

- Document challenges to increasing medical surge capacity in inpatient settings and for EMS.

Activity 2: Improve out-of-hospital medical surge response.

- Assure local coordination with outpatient settings and other out-of-hospital services and include these facilities in alternate care system planning to decrease the stress on inpatient facilities.

- Establish coordinated policies and procedures that integrate EMS response and patient destination choices with outpatient health care facilities.

- Document challenges to increasing medical surge capacity in outpatient settings.

Activity 3: Develop a clinical virtual support system and alternate care telephonic support system.

- Describe how telephone/telemedicine/virtual support will be used to effectively share subspecialty expertise during disasters throughout the state and/or region.

- Demonstrate how critical care medical direction and oversight (adult and pediatric) may be provided during a medical surge response by using telemedicine.

Objective 4: Plan for and Coordinate Health Care Evacuation and Relocation

Activity 1: Identify shortcomings in patient evacuation and relocation plans.

- Identify and address any shortcomings in existing patient evacuation and relocation plans across the geographic area (e.g. heavy reliance on a single vendor and other redundancies).

- Establish MOUs among health care and EMS entities across the state (and, where possible and necessary, with neighboring states) to facilitate secondary distribution of patients and resources via ground and air transfer to balance health care demand.

Activity 2: Describe the process for patient tracking and transport.

- Describe the process for patient tracking and transport across coalitions and/or jurisdictional boundaries and outside of regular referral patterns during a catastrophic event, including medical

operations coordination centers, transport of high-consequence infectious patients and others who may require specialized care during evacuation and relocation.

- Describe the process for family notification and family reunification when patients are evacuated or discharged out of health care settings during a catastrophic event.

Objective 5: Maintain Access to Supplies and Equipment during an Emergency

Activity 1: Assess supply chain integrity.

- Assess the degree to which facility and coalition supply chain integrity could be impacted by a large-scale event that impacts a large proportion of the state (e.g., heavy reliance on a single vendor and other redundancies) and develop a joint understanding of strategies to address the vulnerabilities.

Activity 2: Assess and address equipment, supply, and pharmaceutical requirements.

- Establish communications and, where possible, written agreements with vendors, MOUs between coalitions, and EMAC between states for durable medical equipment (DME), disposable supplies, medical gases, PPE, blood, and pharmaceuticals.

Capability 4: Improve Statewide and Regional Situational Awareness

Objective 1: Utilize Information Sharing Procedures and Platforms

Activity 1: Coordinate statewide health care situational awareness.

- Coordinate statewide/regional health care situational awareness through a centralized Medical Operations Coordination Cell (MOCC) that can integrate key information sharing functions (establishment of situational awareness, sharing of clinical expertise, etc.) with the state emergency operations center (EOC) or equivalent during a response.

- Identify the roles of the partners who should report to the MOCC.

- Define the essential elements of information (EEIs) to be shared in an emergency to facilitate medical surge response (e.g., number of patients, severity and types of illnesses or injuries, operating status, resource needs and requests, bed availability).

- Define the EEIs necessary for patient movement and patient tracking.

- Define the EEIs necessary for regional (i.e., interstate) health care situational awareness and decision-making (e.g., laboratory data, statewide surge capacity, etc.).

- Develop a roadmap to create an interoperable IT system that allows for the collection and sharing of EEIs and other real-time situational awareness of the operating status of the health care system.

Activity 2: Identify information access and data protection procedures.

- Establish necessary data use agreements, policies, and data protection procedures to protect health care information systems and networks.

Activity 3: Utilize communication systems and platforms.

- Demonstrate integration and coordination across information sharing systems to establish a common operating picture and shared situational awareness across the state and/or region; describe the design and any challenges to its establishment.

- Develop processes and procedures to rapidly acquire and share clinical knowledge among health care providers and health care organizations during responses to a variety of emergencies (e.g., CBRN, trauma, burn, pediatrics, or highly infectious disease); this could include leveraging HCCs, conference calls, newsletters, trainings, telehealth/telemedicine, and other means.

Capability 5: Develop Readiness Metrics and Conduct an Exercise to Test Capabilities

Objective 1: Test and Refine Existing Readiness Metrics, Developing Additional Metrics As Needed

Activity 1: In collaboration with ASPR, test, develop, and implement readiness metrics for peer review assessments, monitoring, recognition reporting, and a "Response Ready" designation program for coalitions.

- Test and leverage metrics developed by existing RDHRS sites that are directly linked to the objectives and activities described in "Capability 2: Align Plans, Policies, Processes, and Procedures Related to Clinical Excellence in Disasters," "Capability 3: Increase Statewide and Regional Medical Surge Capacity," and "Capability 4: Improve Statewide and Regional Situational Awareness." Further refine and develop additional metrics as needed.

- Develop a capacity and capability analysis template that is based on the readiness standards and can be used as the basis for an annual readiness assessment of coalitions.

Objective 2: Conduct an Exercise to Test Medical Surge and Situational Awareness Capabilities

Activity 1: Conduct at least one readiness exercise during the project period that measures the readiness of the coalitions' surge capacity and demonstrates the ability to coordinate health care service delivery at the statewide and/or regional (i.e., interstate) level.

- The readiness exercise must test and evaluate a majority of capabilities listed in "Capability 2: Align Plans, Policies, Processes, and Procedures Related to Clinical Excellence in Disasters," "Capability 3: Increase Statewide and Regional Medical Surge Capacity," and "Capability 4: Improve Statewide and Regional Situational Awareness."

- The exercise should also include initial event recognition and activation of the medical operations coordination center to facilitate patient and bed tracking, and integration of clinical expertise into decision-making.

- The exercise should include a test of the implementation of alternate care systems in addition to

the delivery of conventional care.

- The readiness exercise should use the newly developed readiness standards and capacity and capability analysis developed under Activity 1 of Capability 5.

- Recipient will conduct and submit one annual After-Action Report and Corrective Action Plan (sample format provided in Attachments F and G, respectively).

Additional Requirements

Project Meetings

- **Every Two-Week Teleconferences.** A conference call between ASPR and the recipient, to include at minimum the Executive Director and the Medical Director, shall occur every two weeks or as directed by the ASPR project officer. During this call, the partnership will discuss the activities during the reporting period, any problems that have arisen, and the activities planned for the ensuing reporting period. The Executive Director may choose to include other key personnel on the conference call to give detailed updates on specific projects, or the ASPR project officer may make this request. The partnership will maintain a table of expected activities, an actions log, and an identified risk log as a means of managing and conducting these teleconferences.

- **Kickoff and Quarterly Meetings (with Government).** The recipient and the Government shall participate in project meetings to coordinate the performance of the cooperative agreement. These meetings may include face-to-face meetings at the partnership site or ASPR/HHS facilities. Such meetings may include, but are not limited to, meetings of the partnership to discuss technical approach and operational capabilities, site visits to partnership facilities, and meetings to discuss the technical, regulatory, and ethical aspects of the program. These meetings will also serve to formulate and agree upon the activities for the subsequent three months. In order to facilitate review of agreement activities, it is expected that the partnership will provide data, reports, and presentations to ASPR, HHS, and/or other U.S. Government personnel as requested by the project officer. Dates for these meetings will be determined post-award.

- **Quarterly Meetings of the Partnership.** As described in Capability 1/Activity 2, the partnership members must meet at least quarterly. All required partnership members should participate, as should the Executive Director and Medical Director. To the extent possible, representatives from the supporting organizations and additional partners may also participate. The purpose of these meetings is to identify and understand roles and responsibilities, formulate and agree on the activities for the subsequent three months, perform a progress check on the activities in the work plan, undergo a budget review, troubleshoot any barriers or challenges related to completing the objectives and activities of this cooperative agreement, and prepare for kickoff and quarterly meetings with ASPR, HHS, and/or other U.S. Government personnel. These meetings may be conducted virtually (e.g., phone or videoconference) or in person.

- **All RDHRS Sites Meetings (with and without Government).** The recipient and existing sites should participate in all RDHRS sites meetings to enhance coordination across RDHRS sites and encourage functioning as a system.

- **Training Opportunities.** Participation in ASPR-sponsored training, workshops, and meetings is essential to the effective implementation of the cooperative agreement. The ASPR project officer will work with recipients to help obtain supporting documentation to ensure participation at mandatory conferences and training workshops. Annual budgets should include travel for appropriate partnership staff to attend the annual Preparedness Summit sponsored by the National Association of County and City Health Officials and the National Healthcare Coalition Preparedness Conference hosted by MESH.

Reporting Requirements

- The recipient will be required to submit quarterly progress reports, including an end of year report using the template provided in Attachment E.

- The recipient will be required to submit an annual After-Action Report and Corrective Action Plan as a result of the exercise conducted as part of Capability 5 using the templates in Attachments F and G, respectively.

II. AWARD INFORMATION

Estimated Total Project Cost:	$3 million dollars
Estimated Funding Amount:	Up to $3 million dollars subject to availability of funds
Award Ceiling:	$3 million
Anticipated Number of Awards:	1
Project Period Length:	12 months (one year)
Anticipated Start Date:	September 30, 2021
Expected Duration of Support:	12 months (one year)
Type of Assistance Instrument:	Cooperative Agreement

The Federal Grant and Cooperative Agreement Act of 1977, 31 U.S.C. 6305, defines the cooperative agreement as like a grant in that a thing of value is transferred to a recipient to carry out a public purpose. However, a cooperative agreement is used whenever substantial federal involvement with the recipient during performance is anticipated. The difference between grants and cooperative agreements is the degree of federal programmatic involvement rather than the type of administrative requirements imposed. This award is subject to the recipient and collaborative requirements and responsibilities set forth in the cooperative agreement outlined in the program announcement under this funding opportunity and are hereby incorporated by reference as terms and conditions of this award.

Substantial federal involvement by the HHS may include but is not limited to the following functions and activities:

1. In accordance with applicable laws, regulations and policies the authority to take corrective actions if detailed performance specifications (e.g., activities in this funding guidance, approved work plan activities, budgets, performance measures and reports) are not met. Review and approval of work plans and budgets before work can begin on a project during the period covered by this assistance or when a change in scope of work is proposed.

2. Review of proposed contracts.

3. Involvement in the evaluation of key recipient personnel supported through this assistance.

4. HHS and recipient collaboration or joint participation in the performance of the activities supported through this assistance.

5. Monitoring to permit specified kinds of direction or redirection of the work because of interrelationships with other projects.

6. Substantial and/or direct operational involvement or participation during the performance of the assisted activity prior to award of the cooperative agreement to ensure compliance with such generally applicable statutory requirements as civil rights, environmental protection, and provision for individuals with access or functional needs.

The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible. The measured success and impact of the partnership demonstration project will be used to inform future decisions regarding funding and expectations of partnerships. Additional demonstration projects may be supported in the future. As with all federal grants, future offerings are dependent on the availability of appropriated funds in subsequent fiscal years and a decision that funding is in the best interest of the federal government.

ASPR may award all or part of the funds, up to $3 million dollars, subject to availability of funds.

III. ELIGIBILITY INFORMATION

Eligible Applicants

To be eligible for an award through this announcement, an entity shall be a partnership consisting of the following required members:

- one or more hospitals, at least one of which shall be a designated trauma center, [19, 20]

[19] For states that do not have trauma centers, partnerships may include trauma centers in neighboring states that are willing to become partners. The application must clearly demonstrate how funds will be shared with the trauma center despite the fact it is in different state from the partnership. The American College of Surgeons sets the standards for trauma center designation. These standards/processes are found at http://www.facs.org/trauma/ntdbacst.html. Simply put, a trauma center (TC) is designated in one of two ways: (1) TC directly contacts the American College of Surgeons (ACS) verification program or (2) the state has passed laws for its own designation process and the designations are done at the state level. In this latter case, states must use the same standards as required by the ACS's verification program.

[20] ASPR strongly encourages partnerships to include an ACS/COT designated level 1 trauma center.

- one or more other local health care facilities, including clinics, health centers, community health centers, primary care facilities, mental health centers, mobile medical assets, or long-term care facilities;

- one or more political subdivisions; one or more states **or** one or more states and one or more political subdivisions; and

- one or more emergency medical service organizations or emergency management organizations.

The applicant will have to designate a **primary recipient**, which according to the statutory authority for this cooperative agreement can be any of the entities listed above (for example, a hospital, or a local health care facility, or a state, or an EMS organization). That primary recipient must represent a multi-entity partnership comprised of the required members described above. While the partnership must include the required members described, there is no limitation on the total number of entities that can participate in the partnership.

Eligible applicants are defined in the statutory authority for this cooperative agreement, section 319C-2(b)(1)(A) of the Public Health Service (PHS) Act (42 U.S.C. § 247d-3b(b)(1)(A)), as amended.

Special Requirements

Required Letters of Support

In addition, the recipient should:

- Have demonstrated past performance of coordinating with health care organizations and health care coalitions across the state.

- Submit with the application package letters of support from:

    - State Offices Public Health/Health

    - Health care coalitions leaders (or points of contact) in the state

    - State Trauma Advisory Council (or equivalent)

    - State Office of Emergency Medical Services

Desired Letters of Support

The recipient should also collaborate with the following individuals and entities within the state, at a minimum, throughout the course of the project period. While letters of support from these entities are not required as part of the application package, applicants may receive additional credit in the application scoring criteria for additional letters of support:

    - NDMS hospitals

- Deployable State Medical Teams[21]
- State Office of Emergency Management
- State Children's Hospital Network (or equivalent)
- Radiation Injury Treatment Network centers
- Acute Care Hospitals/Medical Centers

Note: In the table provided in Attachment I, please clearly signify which, if any, letters of support in the desired letters of support attachment should be taken into account when evaluating funding priorities and denote the name of each entity and the relevant page number within the application.

Table of Required Partners

Applicants must provide a table reflecting the names and affiliations of all required members in the partnership, using the template provided in Appendix H.

Information for any additional (desired, not required) partners that have provided letters of support (for example, from state hospital associations, etc.) may also be included, but it is not required to do so.

Executive Director and Medical Director Qualifications

- With the application package, the recipient must submit a curriculum vitae (CV) or biosketch of key personnel, including that of the Executive Director and Medical Director, as well as of any technical consultants that are essential to the execution of this cooperative agreement.
- Key personnel are defined as all individuals who contribute in a substantive, meaningful way to the scientific development or execution of the project, whether or not salaries are requested.
- Each CV or biosketch should be no more than five pages each, and while there is no required format, CVs or biosketches should be double-spaced, on 8 ½" x 11" plain white paper with 1" margins on all sides, and a font size of not less than 11.
- CVs or biosketches should clearly convey the required qualifications of the position (if defined in the notice of funding opportunity) and/or any specialized expertise and experience that enables the personnel to complete the assigned roles and responsibilities under the cooperative agreement.
- The Executive Director must meet or exceed the following qualifications:
    - Broad knowledge of modern health care administration, systems, practices and principles
    - Five or more years senior management experience

[21] Deployable State Medical Teams refers to disaster medical assistance teams generally (e.g., NGO-, state-, or health care system-run disaster medical assistance teams) and is not synonymous with federal National Disaster Medical System (NDMS) DMAT teams.

- Solid, hands-on, budget management skills, including budget preparation, analysis, decision-making and reporting
- Strong organizational abilities including planning, delegating, program development, and task facilitation
- Ability to convey a vision of the RDHRS and partnership strategic future to staff, partners, and volunteers through strong written and oral skills

- The Medical Director must meet or exceed the following qualifications:
  - Physician with a current in-state license and demonstrated clinical experience
  - Board Certified in an American Board of Medical Specialties recognized specialty and clinically active
  - Familiarity with EMS, emergency management, and public health laws and regulations
  - Education and/or experience with mass casualty, bioterrorism, nuclear, biological, chemical, weapons of mass destruction and/or disaster preparedness[22]

Additional Statutory Requirements

- The Secretary may not award a cooperative agreement to an eligible entity unless the application submitted by the entity is coordinated and consistent with an applicable State All-Hazards Public Health Emergency Preparedness and Response plan and relevant local plans.
- The recipient shall, to the extent practicable, ensure that activities carried out under this award are coordinated with activities of relevant local Metropolitan Medical Response Systems (MMRS), local Medical Reserve Corps (MRC), and the Cities Readiness Initiative (CRI).

Other Important Notes about this Notice of Funding Opportunity

Guidance to Partnerships

A political subdivision shall not participate in more than one partnership described in this announcement. It is expected that only one partnership will apply from any state because all the required collaborating partners will agree on and support one applicant.

IV. COST SHARING AND MATCHING

Cost Sharing and Match Requirements

There is no cost sharing or match requirement for this project. This project does include maintenance of effort requirement as specified in section 319C-2(h).

[22] While the position's job responsibilities and salary are designed to encompass work of a .25 FTE, the expectation of the employer is not limited to a set number of work hours, but rather the completion of all necessary tasks to meet the objectives of the cooperative agreement that would naturally be attributed to the chief clinician.

- In general, an entity that receives an award under this section shall maintain expenditures for health care preparedness at a level that is not less than the average level of such expenditures maintained by the entity for the preceding two-year period.

- Rule of construction: nothing in this section shall be construed to prohibit the use of awards under this section to pay salary and related expenses of public health and other professionals employed by state, local, or tribal agencies who are carrying out activities supported by such awards (regardless of whether the primary assignment of such personnel is to carry out such activities).[23]

V. APPLICATION AND SUBMISSION INFORMATION

Address to Request Application Package

Application materials can be obtained from http://www.grants.gov.

The contact person regarding this Notice of Funding Opportunity is Virginia Simmons.

Required Registrations

Applicants must register with the System for Award Management (SAM) and Grants.gov (see below for all registration requirements).

1. GET REGISTERED

You are required to complete **three (3) registration processes:**

1. Dun & Bradstreet Data Universal Numbering System (to obtain a DUNS number);
2. System for Award Management (SAM); and
3. Grants.gov

If this is your first time applying, you must complete all three registration processes. If you have already completed registrations for DUNS and SAM, you need to ensure that your accounts are still active, and then register in Grants.gov. **If your organization is not registered by the deadline, the application will not be accepted.**

The organization must maintain an active and up-to-date SAM and DUNS registrations for ASPR to make an award.

1.1 Dun & Bradstreet Data Universal Numbering System (DUNS) Registration

Applicants are required to obtain a valid DUNS Number, also known as the Unique Entity Identifier, and provide that number in the application. Obtaining a DUNS number is easy and there is no charge.

[23] SEC. 202. None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanisms, at a rate in excess of Executive Level II

To obtain a DUNS number, access the Dun and Bradstreet website at: http://www.dnb.com or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that you are a public/private nonprofit organization getting ready to submit a federal grant application. **The DUNS number you use on your application must be registered and active in the System for Award Management (SAM).**

1.2 System for Award Management (SAM) Registration

You must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information during the period your organization has an active federal award or an application under consideration by an agency. To create a SAM user account, register/update your account, and/or search records, go to https://www.sam.gov.

It is also highly recommended that you renew your account prior to the expiration date. **SAM information must be active and up-to-date and should be updated at least every 12 months to remain active (for both recipients and sub-recipients).** Once you update your record in SAM, it will take 48 to 72 hours to complete the validation processes. Grants.gov rejects electronic submissions from applicants with expired registrations.

1.3 Grants.gov Registration

Grants.gov is an online portal for submitting federal grant applications. It requires a one-time registration in order to submit applications. While Grants.gov registration is a one-time only registration process, it consists of multiple sub-registration processes (i.e., DUNS number and SAM registrations) before you can submit your application.

You can register to obtain a Grants.gov username and password at http://www.grants.gov/web/grants/register.html.

If this is your first time submitting an application through Grants.gov, registration information can be found at the Grants.gov "Applicants" tab.

The person submitting your application must be properly registered with Grants.gov as the Authorized Organization Representative (AOR) for the specific DUNS number cited on the SF-424 (first page). See the Organization Registration User Guide for details at the following Grants.gov link: http://www.grants.gov/web/grants/applicants/organization-registration.html.

Application Screening Criteria

Applications that fail to meet the screening criteria described below will not be reviewed and will receive no further consideration. Applications should be submitted electronically via https://www.grants.gov by September 20, 2021.

Applications that do not meet the following responsiveness criteria will be administratively eliminated and will not be reviewed:

- Applications submitted after the due date and time will not be reviewed.
- Applications submitted by non-eligible entities will not be reviewed.

- Applications submitted by individuals or by partnerships that do not meet the criteria will not be reviewed.
- Applications failing to include the required forms will not be reviewed.
- Applications that fail to submit letters of support from the State Offices Public Health/Health, health care coalitions leaders (or points of contact) in the state, State Trauma Advisory Council (or equivalent), and State Office of Emergency Medical Services will not be reviewed.
- ASPR will not accept applications with a project narrative that exceeds 12 pages. NOTE: The table of contents, letters of support, budget narrative and justification forms, CV of key project personnel and other relevant appendices (e.g., partner table, statement of funding preference, Attachment C) are not counted as part of the project narrative for purposes of the 12-page limit.

Content and Form of Application Submission

Table 1. Application Component Guide / Recommended Order of Materials

Component	Subcomponent	Attachments	Required?
Cover Page	N/A		No
Table of Contents	N/A		No
Budget Forms	Application for Federal Assistance – Standard Form SF 424	Attachment A	Yes
	Budget Information – Standard Form SF 424A	Attachment A	Yes
	Assurances (Non-Construction Programs) - Standard Form SF 424B		Yes
Project Narrative	**Overview**		Yes
	Work Plan and Timeline of Proposed Activities	Attachment C*	Yes
	Organizational Capability		Yes
	Evaluation and Performance Measurement Plan	Attachment D	Yes
Relevant Appendices	Table of Required Partners	Attachment H	Yes**
	Key Personnel CV		Yes, for key project staff

Component	Subcomponent	Attachments	Required?
	Memoranda of Agreement or Memoranda of Understanding		Yes, for required members of the partnership
	Required Letters of Support		Yes, of required supporting organizations and additional partners listed in the special requirements section
Relevant Appendices	Desired Letters of Support *Note: In the table provided in Attachment I, please clearly signify which, if any, letters of support in the desired letters of support attachment should be taken into account when evaluating funding priorities and denote the name of each entity and the relevant page number within the application.*	Attachment I	No
	Budget Narrative	Attachment B	Yes
	Indirect Cost Agreement		Yes, if requesting indirect costs
Funding Priorities	Desired Letters of Support *Note: In the table provided in Attachment I, please clearly signify which, if any, letters of support in the desired letters of support attachment should be taken into account when evaluating funding priorities and denote the name of each entity and the relevant page number within the application.*	Attachment I	Yes, if requesting funding priorities
Funding Preferences	Statement that the applicant is eligible for a funding preference, identifying and requesting the applicable preference.	Attachment J	Yes, if requesting funding preferences
	Documentation of qualification (e.g., relevant letters of support, Joint Risk Assessment, etc.)	Attachment J	Yes, if requesting funding preferences

Notes

*The **bolded** items count toward the 12-page limit for the project narrative, with the exception of information provided in the Attachment C template; the required narrative for the work plan and timeline of proposed activities will count toward the page limit, but the use of Attachment C (or a modified version of it) will not.

Component	Subcomponent	Attachments	Required?
**Please include information for all required members of the partnership. Supporting organizations and additional partners may, but do not need, to be included.			

Cover Page and Table of Contents

A cover page and table of contents are encouraged, but not required, in order to facilitate efficient review and to ensure that all required materials are included.

Budget Forms

The following documents and sections need to be submitted to ASPR in order to be considered for funding; forms are available on grants.gov within the application package:

- Application for Federal Assistance – Standard Form SF 424
- Budget Information – Standard Form SF 424A
- Assurances (Non-Construction Programs) - Standard Form SF 424B

Project Narrative

The Project Narrative must be double-spaced, on 8 ½" x 11" paper with 1" margins on both sides, and a font size of not less than 11. You can use smaller font sizes to fill in the standard forms and sample formats. ASPR will not accept applications with a project narrative that exceeds 12 pages. The table of contents, project work plan in the Appendix C template format, letters of support, budget narrative and justification, CV of key project personnel and other relevant appendices (e.g., partner table, statement of funding preference, Attachment C) are not counted as part of the project narrative for purposes of the 12-page limit.

The components of the project narrative counted as part of the page limit include:

1. Overview
2. Work plan and timeline of proposed activities – these plans should be in narrative form and may be accompanied by an additional table (see Attachment C for suggested format) that will not be counted as part of the page limitation. Any narrative submitted to meet this required section will be counted as part of the page limitation. Applicants should provide their proposed approach to all objectives and activities, noting regional priorities as able, in:
    a. Capability 1: Build a Partnership for Disaster Health Response
    b. Capability 2: Align Plans, Policies, Processes, and Procedures Related to Clinical Excellence in Disasters
    c. Capability 3: Increase Statewide and Regional Medical Surge Capacity

d. Capability 4: Improve Statewide and Regional Situational Awareness

e. Capability 5: Develop Readiness Metrics and Conduct an Exercise to Test Capabilities

3. Organizational capability – the organizational capability section should be in narrative and/or chart form, at the discretion of the applicant. Any forms submitted to meet this required section will be counted as part of the 12-page limitation.

4. Evaluation and performance measurement plan – these plans may be in narrative or chart form (see Attachment D for suggested guidelines). Any forms submitted to meet this required section will be counted as part of the 12-page limitation.

Any other relevant appendices that do not count toward the page limit include:

- Table of required partners – template can be found in Appendix H. Please include information for all required members of the partnership. Supporting organizations and additional partners may, but do not need, to be included.

- Key personnel CV – Executive Director, Medical Director, and any technical consultants that are part of this project.

- Memoranda of understanding – of required members of the partnership.

- Letters of support – of required supporting organizations and additional partners listed in the special requirements section.

- Budget narrative – see suggested format in Attachment B.

- Other documents and required forms, as needed – this includes the Standard Form 424, Standard Form 424A, and Standard Form 424B.

- Attachment C – the required narrative for the work plan and timeline of proposed activities will count toward the page limit, but the use of Attachment C (or a modified version of it) will not.

- Indirect Cost Agreement – if requesting indirect costs.

The project narrative is the most important part of the application, since it will be used as the primary basis to determine whether the project meets the minimum requirements of this cooperative agreement. The project narrative should provide a clear and concise description of the project. ASPR recommends that the project narrative include the following components:

Overview

This section provides a brief (no more than one page) summary of the application. Because the overview is often distributed to provide information to the public and Congress, please prepare a narrative that is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project, and must include the following components:

- the defined geographic area being served by the partnership
- gaps to be addressed
- partners represented, and
- a summary of the proposed activities, timelines, and deliverables.

Work Plan and Timeline of Proposed Activities

Each proposed grant activity should have clear timelines for execution and completion. The project work plan should reflect and be consistent with the overview and budget and should cover all of the project period. It should include a statement of the project's overall goal, anticipated outcome(s), key objectives, and the major tasks/action steps that will be pursued to achieve the goal and outcome(s). For each major task/action step, the work plan should identify timeframes involved (including start- and end-dates), and the lead person responsible for completing the task. Please use the work plan format included in Attachment C.

Organizational Capability

The organizational capability statement should describe how the primary applicant agency and the required partner agencies are organized, the nature and scope of their work and/or the capabilities each possesses.

It should also include a description of how applicants have demonstrated past performance of coordinating with health care organizations and health care coalitions across the state, including a description of previous partnerships/projects with the supporting organizations and additional partners that have included letters of support in the application package.

This description should cover capabilities of the applicants that have not been included elsewhere in the narrative, such as any current or previous relevant experience and/or the record of the project team in producing cogent and useful reports, publications, or other products. It should include a relevant description of the capabilities and experience of any of the supporting organizations and additional partners that have provided letters of support as part of the application process.

This section should also include a clear delineation of the roles and responsibilities of project staff (e.g., Executive Director, Medical Director, and any program or technical staff), consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes. It should specify who would have day-to-day responsibility for key tasks such as: leadership of the project; monitoring the project's on-going progress; preparation of reports; and communications with other partners.

Evaluation and Performance Measurement Plan

At the time of application, the recipient must include in their project narrative a brief description of how they plan to fulfill the requirements described in the "Work Plan and Timeline of Proposed Activities" and "Evaluation and Performance Measurement Plan" sections of this NOFO. The recipient also must briefly outline the scope of work, planned activities, and intended outcomes of work performed via

subrecipients.

The evaluation plan is a written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan is used to describe how the recipient and/or ASPR will determine whether activities are implemented appropriately, and outcomes are achieved.

The evaluation plan should track progress related to the objectives, activities, tasks, and outcomes that the applicant is promising to deliver. The plan should be able to describe how outcomes are achieved, and how these outcomes are related to the required performance measures in the award administration information/reporting requirements section.

ASPR does not require recipients to follow a specific evaluation template but provides sample guidelines for developing an evaluation plan in Attachment D.

Appendices

Personnel

Please attach a (no more than five pages each) CV for key project staff, to include the Executive Director and Medical Director. Neither CV nor an organizational chart will count towards the narrative page limit. Also include information about any contractual organization(s) that will have a significant role(s) in implementing the project and achieving project goals.

Memoranda or Agreement or Memoranda of Understanding & Letters of Support

Include confirmation of the commitments to the project (should it be funded) made by key collaborating organizations of the partnership, in the form of signed MOA or MOU. Include also letters of support from the supporting organizations and additional partners. In addition, any organization that is specifically named to have a significant role in carrying out the project should be considered an essential collaborator and a letter of support should be submitted. Neither MOA/MOU nor letters of support will count towards the narrative page limit.

The following assurances should be included in the MOA/MOU or letter of support from the relevant agency:

1. A statement of assurance from the state, territory or directly-funded metropolitan area public health agency(ies) participating in the partnership attesting to the fact that:

    a. This application, work plan, and budget were prepared in consultation with the lead health officials of the state, territory or directly-funded metropolitan area public health agency(ies), and

    b. That this application is coordinated and consistent with the State All-Hazards Public Health Emergency Preparedness and Response Plan and relevant local plans.

2. A statement of assurance from the state, territory or directly-funded metropolitan area public health agency(ies) participating in the partnership stating that to the extent practicable, the activities carried out under this award are coordinated with activities of relevant local Metropolitan Medical Response Systems (MMRS), local Medical Reserve Corps (MRC), and the Cities Readiness Initiative (CRI).

Budget Narrative

The budget narrative/justification should be provided. The budget narrative is used to determine reasonableness and allowability of costs for the project. All the proposed costs listed must be reasonable, necessary to accomplish project objectives, allowable in accordance with applicable federal cost principles [45 CFR part 75 Subpart E – Cost Principles; 45 CFR 75.403 Factors Affecting Allowable Costs; Appendix IX to Part 75—Principles for Determining Costs Applicable to Research and Development Under Grants and Contracts with Hospitals], auditable, and incurred during the budget period.

A sample format is included as Attachment B of this NOFO. Applicants are encouraged to pay attention to Attachment B, which provides an example of the level of detail sought.

Indirect Cost Agreement

Please enclose a copy of the applicant's most recent indirect cost agreement, if requesting indirect costs. Upon issuing a contract or sub-award copies of their indirect cost agreements must be forwarded to the Division of Contracting and Grants.

Submission Deadline Dates and Times

1. A technical assistance conference call will be held on Monday, August 30 at 1:00 PM ET to address any questions associated with the application process. Participants may register for the technical assistance call by visiting: https://deloitte.zoom.us/meeting/register/tJcvduuuqT4sEtz2CWR2_8KjDWcYPxK0kGI4

2. The deadline for the submission of applications under this Notice of Funding Opportunity is September 20, 2021]. Applications must be submitted electronically by 11:59 PM ET on September 20, 2021.

Intergovernmental Review

This Notice of Funding Opportunity is not subject to the requirements of Executive Order 12372, "Intergovernmental Review of Federal Programs."

Funding Restrictions

Grant funds may be used to cover costs of personnel, consultants, equipment, supplies, grant-related travel, and other grant-related costs pending prior approval.

Restrictions, which must be considered while writing the budget, are as follows:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care. For the purposes of this NOFO, clinical care is defined as "directly managing the medical care and treatment of patients."
- Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
- Recipients may not generally use HHS/ASPR/HPP funding for the purchase of furniture. Any such proposed spending must be identified in the budget.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Recipients may not use funds to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: provided that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant state or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the state or local jurisdiction, as applicable, is experiencing or is at risk for a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with state and local law.
- Recipients may not use funds to advocate or promote gun control.
- Salaries may not exceed the rate of $199,300 USD per year.
- Recipients may not use funds for lobbying activities.
- Recipients may not use funds for fund raising.
- Recipients may not use funds for the cost of money even if part of the negotiated indirect cost rate agreement.
- Recipients may not use funds for purchase of vehicles.
- Recipients may not use funds for salaries for back filling of personnel.
- Recipients may not use funds for antibiotics for treatment of secondary infections.
- Funding under these awards may only be used for minor alteration and renovation (A&R) activities. Construction and major A&R activities are not permitted. A&R of real property generally is defined as work required to change the interior arrangements or installed equipment in an existing facility so that it may be more effectively utilized for its currently designated purpose or be adapted for an alternative use to meet a programmatic requirement. The work may be categorized as improvement, conversion, rearrangement, rehabilitation, remodeling, or modernization, but it does not include expansion, new construction, development, or repair of parking lots, or activities that would change the "footprint" of an existing facility (e.g., relocation of existing exterior walls, roofs, or floors; attachment of fire escapes). Minor A&R may include activities and associated costs that will result in:

- Changes to physical characteristics (interior dimensions, surfaces, and finishes); internal environments (temperature, humidity, ventilation, and acoustics); or utility services (plumbing, electricity, gas, vacuum, and other laboratory fittings);
- Installation of fixed equipment (including casework, fume hoods, large autoclaves, biological safety cabinets);
- Replacement, removal, or reconfiguration of interior non-load bearing walls, doors, framed, or windows in order to place equipment in a permanent location;
- Making unfinished shell space suitable for purposes other than human occupancy, such as storage of pharmaceuticals; or,
- Alterations to meet requirements for accessibility by individuals with physical disabilities.

VI. APPLICATION REVIEW INFORMATION

As discussed above, the goal of this NOFO is to fund one demonstration project that will help identify issues, develop leading practices, and demonstrate the potential effectiveness and viability of the RDHRS concept. ASPR envisions this as a cooperative process.

It is expected that one partnership should apply from any state because all the required collaborating partners will agree on and support one applicant.

Review and Selection Process

An objective review committee comprised of reviewers who are experts in their field and may be drawn from academic institutions, non-profit organizations, state and local government, and federal government agencies will evaluate each application that passes the screening criteria. Based on the application review criteria, the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the identified criteria.

Final award decisions will be made by ASPR. In making these decisions, ASPR will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government considering the available funding and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

The following scoring system will be used:

1. Approach – (5%)
2. Organizational Capacity – (36%)
3. Work Plan – (52%)
4. Budget – (2%)
5. Project Relevance and Evaluation – (5%)

The application will be reviewed using the following criteria:

Required Components – Maximum Points: 100

Approach

Does the applicant provide the required MOA or MOU from partnership members and required letters of support (and any required assurances) from State Offices of Public Health/Health, health care coalitions leaders (or points of contact) in the state, the State Trauma Advisory Council (or equivalent), and State Office of Emergency Medical Services? [5 points]

Organizational Capacity

Do the applicant's key personnel (e.g., Executive Director and Medical Director) have the capability and prior experience listed in the eligibility information/special requirements section reflected in their CV? [5 points for Executive Director qualifications and 5 points for Medical Director qualifications (10 points total)]

Does the partnership demonstrate organizational capability and prior experience as described in sub-bullets 1-5 (shown below)? [15 points]

1. Demonstrated past performance of coordinating with health care organizations and health care coalitions across the state;

2. Developing and maintaining a relationship among the required partners listed in Capability 1;

3. Performing the functions required of the Partnership and described in Capabilities 2-4;

4. Establishing performance metrics as required under Capability 5; and

5. Conducting a statewide or regional (i.e. multi-state) level exercise as required under Capability 5?

Does the primary recipient in the partnership have experience with direct patient care and sharing of clinical expertise across the state and/or region? Does the primary recipient demonstrate capability for the ongoing, complex clinical management of patients requiring specialty expertise in (1) chemical, (2) radiation, (3) burn, (4) trauma, (5) high consequence infectious disease, and/or (6) pediatric care? [6 points]

Does the applicant include a clear delineation of the roles and responsibilities of project staff (e.g., Executive Director, Medical Director, and any program or technical staff), consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes? [5 points]

Budget

Does the applicant provide additional information about any contractual organization(s) that will have a significant role(s) in implementing the project and achieving project goals? [2 points]

Work Plan

Does the applicant describe in the work plan and timeline a clear technical approach for each objective and activity listed in:

1. Capability 1: Build a Partnership for Disaster Health Response; [4 points]
2. Capability 2: Align Plans, Policies, Processes, and Procedures Related to Clinical Excellence in Disasters; [12 points]
3. Capability 3: Increase Statewide and Regional Medical Surge Capacity; [12 points]
4. Capability 4: Improve Statewide and Regional Situational Awareness; [12 points] and
5. Capability 5: Develop Readiness Metrics and Conduct an Exercise to Test Capabilities? [12 points]

Project Relevance and Evaluation

Does the applicant address how the required objectives, activities, and tasks will be monitored and reported on in the evaluation and performance measurement plan? [5 points]

Funding Priorities and Preferences

For these awards, ASPR will use funding priorities and preferences.

Funding Priorities

A funding priority is defined as the favorable adjustment of combined review scores of individually approved applications when applications meet specified criteria. This adjustment shall be up to a total of 5 possible points, with points assigned as listed below. Eligibility for the adjustment will be determined by ASPR staff and will be based on information included in the additional letters of support from the desired partners listed below:

a. Deployable State Medical Teams[24]; [.5 point]
b. State Office of Emergency Management; [.5 points]
c. State Children's Hospital Network (or equivalent); [.5 point]
d. Radiation Injury Treatment Network centers; [.5 point] and
e. Acute Care Hospitals/Medical Centers [.5 point for each, up to 3 total points]

Note: In the table provided in Attachment I, please clearly signify which, if any, letters of support in the desired letters of support attachment should be taken into account when evaluating funding priorities and denote the name of each entity and the relevant page number within the application.

Funding Preferences

Statutory funding preferences are available to applicants. A funding preference is defined as the funding

[22] Deployable State Medical Teams refers to disaster medical assistance teams generally (e.g. NGO-, state-, or health care system-run disaster medical assistance teams) and is not synonymous with federal National Disaster Medical System (NDMS) DMAT teams.

of a specific category or group of approved applications ahead of other categories or groups of approved application that do not carry a preference. Applicants receiving the preference will be placed in a more competitive position among applicants that can be funded. Applications that do not receive a funding preference will be given full and equitable consideration during the review process. Qualification for the preference will be determined by ASPR staff. To receive a funding preference, include a statement that you are eligible for a funding preference and identify and request the applicable preference, using the template provided in Attachment J. Documentation must be enclosed or clearly signified as Funding Preference documentation in other components of the application.

Funding preferences are available to qualified applicants that specifically request and demonstrate that they meet the criteria for the preference(s) as follows:

Qualification 1: Regional Coordination

The partnership demonstrates how it will enhance coordination among the hospitals and designated trauma center and between other local health care facilities, including clinics, health centers, community health centers, primary care facilities, mental health centers, mobile medical assets, or long-term care facilities, and includes a significant percentage (greater than 51 percent) of the hospitals and health care facilities within the geographic area served by such partnership.

This qualification may be demonstrated, for example, by the submission of letters of support from a majority or all of the health care coalition leaders (or point of contact (POC)) in the state and/or by the inclusion of documentation to show the applicant has existing partnerships with these facilities through other means. Applicants must provide enough documentation for ASPR staff to easily discern the percentage of hospitals and health care facilities included in the partnership to be considered for this statutory preference.

Qualification 2: National Disaster Medical System (NDMS)

The partnership includes facilities participating in the National Disaster Medical System. These hospitals must be clearly identified as NDMS participating facilities in the application and in their submitted letters of support (if applicable).

Qualification 3: Degree of Risk

Partnerships are in a geographic area that faces a high degree of risk. This should be based on the most recent state Joint Risk Assessment (within the last five years), which must be enclosed to be considered for this statutory preference.

Qualification 4: Significant Need

Application clearly demonstrates a significant need for funds to achieve the medical preparedness goals described in this guidance. Applications should clearly delineate whether the partnership receives funds from the Hospital Preparedness Program, CDC Public Health Emergency Preparedness grants, or other Department of Homeland Security (DHS) grants and how these funds will be used to complement and/or leverage other preparedness funding for partnership activities.

VII. AWARD ADMINISTRATION INFORMATION

Award Notices

The Notice of Award is the authorizing document from the ASPR authorizing official, the Division of Contracting and Grants, and the Division of Finance. The Notice of Award will be sent electronically upon successful review of the application. The Notice of Award sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-federal share to be provided (if applicable), and the total project period for which support is contemplated.

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the expert committee's assessment of the application's strengths and weaknesses, and whether the application was selected for funding. Applicants who are selected for funding may be required to respond in a satisfactory manner to Conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

Administrative and National Policy Requirements

The award is subject to HHS Administrative Requirements, which can be found in 45 CFR 75 and the HHS Grants Policy Statement located at https://www.hhs.gov/grants/grants/grants-policies-regulations/index.html. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award). References in the HHS Grants Policy Statement to 45 CFR part 74 or 45 CFR part 92 have been superseded by 45 CFR 75.

Non-Discrimination Requirements

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS must administer their programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). This includes ensuring programs are accessible to persons with limited English proficiency and persons with disabilities. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html and https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html.

- Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals. See https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html and https://www.lep.gov.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including reasonable modifications and making services accessible to them, *see* http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html.
- HHS funded health and education programs must be administered in an environment free of sexual harassment, *see* https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.

- For guidance on administering your program in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, *see* https://www.hhs.gov/conscience/conscience-protections/index.html and https://www.hhs.gov/conscience/religious-freedom/index.html.

System for Award Management (SAM) Reporting

A term may be added to the Notice of Award that states: "In accordance with the regulatory requirements provided at 45 CFR 75.113 and Appendix XII to 45 CFR Part 75, recipients that have currently active federal grants, cooperative agreements, and procurement contracts with cumulative total value greater than $10,000,000, must report and maintain information in the System for Award Management (SAM) about civil, criminal, and administrative proceedings in connection with the award or performance of a federal award that reached final disposition within the most recent five-year period. The recipient also must make semiannual disclosures regarding such proceedings. Proceedings information will be made publicly available in the designated integrity and performance system (currently the Federal Awardee Performance and Integrity Information System (FAPIIS)). Full reporting requirements and procedures are found in Appendix XII to 45 CFR Part 75."

Drug-Free Workplace

A term may be added to the Notice of Award that states: "You as the recipient must comply with drug-free workplace requirements in Subpart B (or Subpart C, if the recipient is an individual) of part 382, which adopts the Government-wide implementation (2 CFR part 182) of section 5152-5158 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701-707)."

Smoke- and Tobacco-free Workplace

The HHS/ASPR strongly encourages all grant recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. This is consistent with the HHS/ASPR mission to protect and advance the physical and mental health of the American people.

NOTE: The signature of the AOR on the application serves as the required certification of compliance for your organization regarding the administrative and national policy requirements.

Temporary Reassignment of State and Local Personnel during a Public Health Emergency

Section 319(e) of the Public Health Service (PHS) Act provides the Secretary of the Department of Health and Human Services (HHS) with discretion upon request by a state or tribal organization to authorize the temporary reassignment of state, tribal, and local personnel during a declared federal public health emergency. The temporary reassignment provision is applicable to state, tribal, and local public health department or agency personnel whose positions are funded, in full or part, under PHS programs and allows such personnel to immediately respond to the public health emergency in the affected jurisdiction. Funds provided under the award may be used to support personnel who are temporarily reassigned in accordance with section 319(e). Please reference detailed information available on the ASPR website via http://www.phe.gov/Preparedness/legal/pahpa/section201/Pages/default.aspx

ASPR Public Access Policy

The ASPR Public Access Policy requires all researchers receiving ASPR grants, cooperative agreements, or fixed amount awards to develop data management plans describing how they will provide for the long-term preservation of, and access to, scientific data in digital format. This ASPR Public Access Policy

applies to any manuscript that is peer-reviewed and arises from any direct funding from an ASPR grant, cooperative agreement or fixed amount award awarded in FY16 or beyond. This policy ensures that the public has access to the published results of ASPR funded grants, cooperative and fixed amount awards at the NIH NLM PubMed Central (PMC), a free digital archive of full-text biomedical and life sciences journal literature (http://www.pubmedcentral.nih.gov/). Under the policy ASPR-funded investigators are required by Federal law to submit (or have submitted for them) to PMC an electronic version of the final, peer-reviewed manuscript upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. On February 22, 2013, the White House Office of Science and Technology Policy (OSTP) released the memorandum entitled, Increasing Access to the Results of Federally Funded Scientific Research, which requires federal agencies to make the results of federally funded scientific research available to and useful for the public, industry, and the scientific community.

This document establishes a governing policy to enable public access to digitally formatted scientific data created with ASPR funds.

Publications

Manuscripts resulting from funded work must be submitted directly to the NIH Manuscript Submission System (NIHMS) http://www.nihms.nih.gov/. At the time of submission, the submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Authors may own the original copyrights to materials they write and should work with the prospective publisher as necessary before any rights are transferred to ensure that all conditions of the ASPR Public Access Policy can be met. Authors should avoid signing any agreements with publishers that do not allow the author to comply with the ASPR Public Access Policy. The author's final peer-reviewed manuscript is defined as the final version accepted for journal publication arising from funds awarded in or after FY16 and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Institutions and investigators are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this policy. Applicants citing articles in ASPR applications, proposals, and progress reports that fall under the policy, were authored or co-authored by the applicant and arose from ASPR support must include the PMCID or NIHMS ID. The NIHMSID may be used to indicate compliance with the ASPR's Public Access Policy in applications and progress reports for up to three months after a paper is published. After that period, a PMCID must be provided to demonstrate compliance.

Digital Data

ASPR-supported researchers must publish digital scientific data sets resulting from projects meeting the scope criteria above in a recognized scientific data repository capable of long-term preservation of the data and open access to the public within a proscribed time period of 30 months from the creation of the data set (if the data set has not been used in a peer-reviewed publication) or upon publication of a peer-reviewed publication based on the data set, whichever is sooner, unless this requirement has been waived in the approved data management plan. ASPR will recognize intellectual property rights as appropriate, consistent with regulations and program policies, including considerations for intellectual property based on the type of data subject to those policies (e.g., varied embargo dates, conditions for delaying data release). For the purpose of this plan, proprietary interests include receiving appropriate credit for scientific work. If the outcomes of the research result in inventions, the provisions of the Bayh-Dole Act

of 1980, as implemented in 37 CFR Part 401, apply.

Acknowledgement

ASPR Public Access Policy requires, all recipient publications, including: research publications press releases other publications or documents about research that is funded by ASPR must include the following two statements:

A specific acknowledgment of ASPR grant support, such as: *"Research reported in this [publication/press release] was supported by [name of the program office(s), or other ASPR offices] the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response under award number [specific ASPR grant number(s)]."* A disclaimer that says: *"The content is solely the responsibility of the authors and does not necessarily represent the official views of the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response."*

Trafficking in Persons

Awards issued under this Notice of Funding Opportunity are subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to http://www.hhs.gov/opa/grants/trafficking_in_persons_award_condition.html. If you are unable to access this link, please contact the Grants Management Officer identified in this Notice of Funding Opportunity to obtain a copy of the term.

Reporting

Applicants funded under this announcement will be required to electronically submit quarterly progress reports and a semi-annual Federal Financial Report (FFR) SF-425. In addition, applicants must submit an annual end-of-year program progress report and annual end-of-year Federal Financial Report, both due 90 days after each 12-month budget period ends. Recipients will receive instructions for both reports with their Notice of Award. Final performance and financial reports are due 90 days after the end of the project period. For more information see HHS/ASPR Standard Terms and Conditions.

Progress Reporting: Applicants funded under this announcement will be required to electronically submit an annual program progress report. As part of the progress report financial information will be reported both per major category of expense and by objective.

Subaward/Subcontract and Executive Compensation Reporting: Applicants must ensure that they have the necessary processes and systems in place to comply with the subaward or subcontract and executive total compensation reporting requirements established under OMB guidance at *2 CFR Part 170*, unless they qualify for an exception from the requirements, should they be selected for funding.

Quarterly Cash Transaction Reporting Recipients must report quarterly cash transaction data using the Federal Financial Report (FFR), SF-425. Recipients will utilize the SF-425 lines 10.a through 10.c to report cash transaction data to the Division of Payment Management. The FFR SF-425 (lines 10.a through 10.c) is due to the Payment Management System 30 days after the end of each calendar quarter. The FFR SF-425 electronic submission and dates for the new quarters will be announced through the Payment Management. Funds will be frozen if the report is not filed on or before the due

date.

Federal Disbursement Reporting: The SF-425 will also be used for reporting of expenditure data to meet ASPR's semi-annual and annual financial reporting requirement. All other lines except 10.a through 10.c should be completed.

Other Reporting Requirements: Throughout the course of the project the recipient may be asked to submit additional reports as needed.

Reporting Requirements / Performance Measures

Performance Measures

1. The partnership demonstrates clearly defined, cooperative, and ongoing relationships to accomplish its mission with the required partners, supporting organizations, additional partners, and with local, regional, and/or state public health agencies and emergency management agencies by:

    a. Actively participating in emergency preparedness planning meetings, activities, and other venues to develop and foster integrative and collaborative relationships engaging private and public capabilities to improve preparedness;

    b. Managing and mobilizing partnership partners to identify issues related to medical emergency preparedness;

    c. Managing, developing, and establishing cooperative linkages through Memoranda of Agreement (MOA)/Memoranda of Understanding (MOU) and/or Compact Agreements;

    d. And participating in drills, tabletops, and full-scale exercises.

2. The partnership has identified critical clinical capabilities and gaps in existing disaster plans, aligned existing coalition and state response plans to facilitate coordinated medical surge, and coordinated and aligned laws, regulations, and policies related to medical surge management in disasters.

3. The partnership has improved medical surge capacity and capability by:

    a. Identifying and providing specialized surge management, expertise, education, and patient care coordination (to include EMS capabilities) during emergencies that result in a surge of (1) chemical, (2) radiation, (3) burn, (4) trauma, (5) high consequence infectious disease, and/or (6) pediatric patients;

    b. Educating and training the health care and medical workforce on identified preparedness and response gaps related to the clinical management of patients;

    c. Developing plans, protocols, and the ability to use ESAR-VHP and MRC volunteers during all phases of emergency management;

d. Drafting a plan for the use of health care surge professionals internal and external to the state;

e. Improving hospital and EMS surge response;

f. Improving out-of-hospital medical surge response;

g. Developing a clinical virtual support system and alternate care telephonic support system;

h. Describing the process for patient tracking and transport;

i. Identifying shortcomings in patient evacuation and relocation plans;

j. Assessing supply chain integrity; and

k. Assessing and address equipment, supply, and pharmaceutical requirements.

4. The partnership has developed, and implemented to the extent feasible, a comprehensive statewide or regional situational awareness (SA) capability that integrates medical resources in order to improve early detection of, response to, and clinical management of all public health and medical emergencies.

    a. The SA capability enables an accurate medical and public health common operating picture.

    b. The SA capability coordinates statewide/regional health care situational awareness through a centralized medical operations coordination center that integrates key information sharing functions with the state EOC (or equivalent) during a response.

5. The partnership develops and implements readiness metrics for peer review assessments, monitoring, recognition reporting, and a "Response Ready" designation program.

6. The Partnership conducts at least one readiness exercise during the project period that measures the readiness of the coalitions' surge capacity and demonstrates the ability to coordinate health care service delivery at the statewide or regional (i.e., multi-state) level.

7. The partnership has submitted timely and complete data for the required reports (quarterly progress and end of year reports). The measure will be scored by ASPR staff. A "yes" requires two conditions to be met:

    a. Each required report is submitted electronically to the Division of Contracting and Grants and the Project Officer by the agreed upon deadlines. Exceptions: a single two-week extension period may be requested in hardship cases, which must be documented and approved in writing by the Division of Contracting and Grants in advance of the due date.

    b. Each report includes all requested information. Exceptions: there are no exceptions. Recipients who require clarification of any requested element or question must contact the project officer in writing at least one week in advance of the report due date.

Partnerships shall maintain all documentation that substantiates the answers to these measures (site visits, surveys, exercises, etc.) and make those documents available to federal staff as requested during site visits or through other requests.

Note: ASPR recognizes that performance measures require significant regional participation, engagement, approval, and alignment. Recipients are encouraged to implement performance measures as able based on regional capacity, noting challenges and potential solutions. ASPR additionally encourages recipients to share challenges and potential solutions related to implementing these performance measures. ASPR may request specific performance measurement information or data related to objectives and activities detailed in this notice of funding opportunity and may ask recipients to share that information if requested. Such a request would not be expected to create additional burden to recipients in addition to ongoing activities and the requirements detailed in this notice of funding opportunity and would be requested with ample time available for preparing the submission.

VIII. AGENCY CONTACTS

Grants Management Officer:

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Preparedness and Response
Washington, DC 20201
Attn: Virginia Simmons
Telephone: (202) 260-0400
E-mail: asprgrants@hhs.gov

Project Officer:

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Preparedness and Response
Washington, DC 20201
Attn: Jennifer Hannah
Deputy Branch Chief
National Healthcare Preparedness Programs
Telephone: (202) 245-0722
E-mail: jennifer.hannah@hhs.gov

IX. OTHER INFORMATION

Required Application Appendices

1. MOA or MOU of required partners
2. Letters of Support from required supporting organizations
3. CV for key project personnel
4. Table of required partners
5. SF 424 – Application for Federal Assistance
6. SF 424A – Budget Information
7. Budget narrative/justification (See Attachment B for a budget narrative/justification sample format with examples).
8. Copy of the applicant's most recent indirect cost agreement, if requesting indirect costs. Upon issuing a contract or sub-award copies of their indirect cost agreements must be forwarded to the Division of Contracting and Grants.

Optional Application Appendices

1. Letters of support from additional partners
2. Statement of funding preference
3. State joint risk assessment

Attachments

- Attachment A: Instructions for Completing Required Forms (SF 424, Budget (SF 424A), SF 424B, and Budget Narrative/Justification)
- Attachment B: Budget Narrative/Justification - Sample Format
- Attachment C: Project Work Plan and Timeline - Sample Template
- Attachment D: Evaluation and Performance Measurement Plan – Sample Template
- Attachment E: Interim and End of Year Report Template
- Attachment F: After Action Report from Exercise – Sample Template
- Attachment G: Corrective Action Plan – Sample Template
- Attachment H: Table of Required Partners

- Attachment I: Funding Priorities
- Attachment J: Funding Preferences – Sample Template

Attachment A: Instructions for Completing Required Forms (SF 424, Budget (SF 424A), Budget Narrative/Justification)

This section provides step-by-step instructions for completing the four (4) standard federal forms required as part of your grant application, including special instructions for completing Standard Budget Forms 424 and 424A. Standard Forms 424 and 424A are used for a wide variety of federal grant programs, and federal agencies have the discretion to require some or all of the information on these forms. ASPR does not require all the information on these Standard Forms. Accordingly, please use the instructions below to complete these forms in lieu of the standard instructions attached to SF 424 and 424A.

a. Standard Form 424

1. **Type of Submission:** (Required): Select one type of submission in accordance with agency instructions.
   - Application

2. **Type of Application**: (Required) Select one type of application in accordance with agency instructions.
   - New

3. **Date Received:** Leave this field blank.

4. **Applicant Identifier**: Leave this field blank

5a **Federal Entity Identifier**: Leave this field blank

5b. **Federal Award Identifier**: For new applications leave blank.

6. **Date Received by State:** Leave this field blank.

7. **State Application Identifier:** Leave this field blank.

8. **Applicant Information**: Enter the following in accordance with agency instructions:

   a. Legal Name (Required): Enter the name that the organization has registered with the Central Contractor Registry. Information on registering with CCR may be obtained by visiting the Grants.gov website (https://www.grants.gov
   Employer/Taxpayer Number (EIN/TIN)(Required): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service.

   c. Organizational DUNS (Required): Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet. Information on obtaining a DUNS number may be obtained by visiting the Grants.gov website

(https://www.grants.gov).

d. Address (Required): Enter the complete address including the county.

e. Organizational Unit: Enter the name of the primary organizational unit (and department or division, if applicable**)** that will undertake the project.

f. Name and contact information of person to be contacted on matters involving this application: Enter the name (first and last name required), organizational affiliation (if affiliated with an organization other than the applicant organization), telephone number (Required), fax number, and e-mail address (required) of the person to contact on matters related to this application.

9. **Type of Applicant** (Required): Select the applicant organization "type" from the drop-down list.

10. **Name of Federal Agency** (Required): Enter U.S. Assistant Secretary for Preparedness and Response

11. **Catalog of Federal Domestic Assistance Number/Title:** The CFDA number can be found on page one of the NOFO.

12. **Funding Opportunity Number/Title** (Required): The Funding Opportunity Number and title of the opportunity can be found on page one of the NOFO.

13. **Competition Identification Number/Title:** Leave this field blank.

14. **Areas Affected By Project:** List the largest political entity affected (cities, counties, state etc.).

15. **Descriptive Title of Applicant's Project** (Required): Enter a brief descriptive title of the project.

16. **Congressional Districts Of** (Required): **16a**. Enter the applicant's Congressional District, and **16b.** Enter all district(s) affected by the program or project. Enter in the following format: 2 characters state abbreviation – 3 characters district number, CA-005 for California 5th district. If all congressional districts in a state are affected, enter "all" for the district number, (e.g. MD-all for all congressional districts in Maryland). If nationwide enter US-all.

17. **Proposed Project Start and End Dates** (Required): Enter the proposed start date and final end date of the project. Therefore, if you are applying for a multi-year grant, such as a 3 year grant project, the final project end date will be 3 years after the proposed start date. The Grants Office can alter the start and end date at their discretion.

18. **Estimated Funding** (Required): Enter the amount requested or to be contributed during

the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines, as applicable.

19. **Is Application Subject to Review by State Under Executive Order 12372 Process?** Check appropriate box.

20. **Is the Applicant Delinquent on any Federal Debt?** (Required): This question applies to the applicant organization, not the person who signs as the authorized representative. If yes, include an explanation on the continuation sheet.

21. **Authorized Representative** (Required): To be signed and dated by the authorized representative of the applicant organization. Enter the name (first and last name required) title (required), telephone number (required), fax number, and e-mail address (required) of the person authorized to sign for the applicant. A copy of the governing body's authorization for you to sign this application as the official representative must be on file in the applicant's office. (Certain federal agencies may require that this authorization be submitted as part of the application.)

b. Standard Form 424A

NOTE: Standard Form 424A is designed to accommodate applications for multiple grant programs; thus, for purposes of this ASPR program, many of the budget item columns and rows are not applicable. You should only consider and respond to the budget items for which guidance is provided below. Unless otherwise indicated, the SF 424A should reflect a one year budget.

Section A - Budget Summary
Line 5: Leave columns (c) and (d) blank. Enter TOTAL federal costs in column (e) and total non-federal costs (including third party in-kind contributions and any program income to be used as part of the recipient match) in column (f). Enter the sum of columns (e) and (f) in column (g).

Section B - Budget Categories
Column 3: Enter the breakdown of how you plan to use the federal funds being requested by object class category (see instructions for each object class category below).

Column 4: Enter the breakdown of how you plan to use the non-federal share by object class category. [DOES NOT APPLY TO THIS NOFO.]

Column 5: Enter the total funds required for the project (sum of Columns 3 and 4) by object class category.

Separate Budget Narrative/Justification Requirement

Applicants requesting funding for multi-year grant programs are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed

Budget Narrative/Justification for each year of potential grant funding. A separate Budget Narrative/Justification is also REQUIRED for each potential year of grant funding requested.

For your use in developing and presenting your Budget Narrative/Justification, a sample format with examples and a blank sample template have been included in these Attachments. In your Budget Narrative/Justification, you should include a breakdown of the budgetary costs for all of the object class categories noted in Section B, across three columns: federal; non-federal cash; and non-federal in-kind. Cost breakdowns, or justifications, are required for any cost of $1,000 or for the thresholds as established in the examples. The Budget Narratives/Justifications should fully explain and justify the costs in each of the major budget items for each of the object class categories, as described below. Non-federal cash as well as, subcontractor or subrecipient (third party) in-kind contributions designated as match must be clearly identified and explained in the Budget Narrative/Justification. The full Budget Narrative/Justification should be included in the application immediately following the SF 424 forms.

Line 6a - **Personnel**: Enter total costs of salaries and wages of applicant/recipient staff. Do not include the costs of consultants, which should be included under 6h - Other.

In the Justification: Identify the project director, if known. Specify the key staff, their titles, and time commitments in the budget justification.

Line 6 - **Fringe Benefits**: Enter the total costs of fringe benefits unless treated as part of an approved indirect cost rate.

In the Justification: If the total fringe benefit rate exceeds 35% of personnel costs, provide a break-down of amounts and percentages that comprise fringe benefit costs, such as health insurance, FICA, retirement, etc. A percentage of 35% or less does not require a break down but you must show the percentage charged for each full/part time employee.

Line 6c - **Travel**: Enter total costs of all travel (local and non-local) for staff on the project. NEW: Local travel is considered under this cost item not under the "Other" cost category. Local transportation (all travel which does not require per diem is considered local travel). Do not enter costs for consultant's travel - this should be included in line 6h.

In the Justification: Include the total number of trips, number of travelers, destinations, purpose (attend conference), length of stay, subsistence allowances (per diem), and transportation costs (including mileage rates).
Line 6d - **Equipment**: Enter the total costs of all equipment to be acquired by the project. For all recipients, "equipment" is non-expendable tangible personal property having a useful life of more than one year and an acquisition cost of $5,000 or more *per unit*. If the item does not meet the $5,000 threshold, include it in your budget under Supplies, line 6e.

In the Justification: Equipment to be purchased with federal funds must be justified as necessary for the conduct of the project. The equipment must be used for project-related

functions. Further, the purchase of specific items of equipment should not be included in the submitted budget if those items of equipment, or a reasonable facsimile, are otherwise available to the applicant or its subrecipients/subcontractors.

Line 6e: **Supplies** - Enter the total costs of all tangible expendable personal property (supplies) other than those included on line 6d.

In the Justification: For any grant award that has supply costs in excess of 5% of total direct costs (federal or non-federal), you must provide a detailed breakdown of the supply items (6% of $100,000 = $6,000 – breakdown of supplies needed). If the 5% is applied against $1 million total direct costs (5% x $1,000,000 = $50,000) a detailed breakdown of supplies is not needed. Please note: any supply costs of $5,000 or less regardless of total direct costs does not require a detailed budget breakdown (5% x $100,000 = $5,000 – no breakdown needed).

Line 6f - **Contractual**: Regardless of the dollar value of any contract, you must follow your established policies and procedures for procurements and meet the minimum standards established in the Code of Federal Regulations (CFR's) mentioned below. Enter the total costs of all contracts, including procurement contracts (except those which belong on other lines such as equipment, supplies, etc.). Note: The 33% provision has been removed and line item budget detail is not required as long as you meet the established procurement standards. Also include any contracts with organizations for the provision of technical assistance. Do not include payments to individuals on this line.

In the Justification: Provide the following three items – 1) a list of contractors indicating the name of the organization; 2) the purpose of the contract; and 3) the estimated dollar amount. If the name of the contractor and estimated costs are not available or have not been negotiated, indicate when this information will be available. The federal government reserves the right to request the final executed contracts at any time. If an individual contractual item is over the small purchase threshold, currently set at $100K in the CFR, you must certify that your procurement standards are in accordance with the policies and procedures as stated in 45 CFR 74.44 for non-profits and 45 CFR 92.36 for states, in lieu of providing separate detailed budgets. This certification should be referenced in the justification and attached to the budget narrative.

Line 6g - **Construction**: While construction is not an allowable cost for this program, minor A&R is permitted.

Line 6h - **Other**: Enter the total of all other costs. Such costs, where applicable, may include, but are not limited to: insurance, medical and dental costs (e.g. for project volunteers this is different from personnel fringe benefits), non-contractual fees and travel paid directly to *individual* consultants, postage, space and equipment rentals/lease, printing and publication, computer use, training and staff development costs (e.g. registration fees). If a cost does not clearly fit under another category, and it qualifies as an allowable cost, then it belongs in this section.

In the Justification: Provide a reasonable explanation for items in this category. For example, individual consultants explain the nature of services provided and the relation to activities in the

Work Plan or indicate where it is described in the Work Plan. Describe the types of activities for staff development costs.

Line 6i - **Total Direct Charges**: Show the totals of Lines 6a through 6h.

Line 6j - **Indirect Charges**: Enter the total amount of indirect charges (costs), if any. If no indirect costs are requested, enter "none." Indirect charges may be requested if: (1) the applicant has a current indirect cost rate agreement approved by the HHS or another federal agency; or (2) the applicant is a state or local government agency. **State governments should enter the amount of indirect costs determined in accordance with HHS requirements.** An applicant that will charge indirect costs to the grant must enclose a copy of the current rate agreement. Indirect Costs can only be claimed on Federal funds, more specifically, they are to only be claimed on the federal share of your direct costs. Any unused portion of the recipient's eligible Indirect Cost amount that are not claimed on the federal share of direct charges can be claimed as un-reimbursed indirect charges, and that portion can be used towards meeting the recipient match.

NOTE: **If indirect costs are to be included in the application, a copy of the approved indirect cost agreement must be included with the application. Further, if any subcontractors or subrecipients are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.**

Line 6k - **Total**: Enter the total amounts of Lines 6i and 6j.

Line 7- **Program Income**: As appropriate, include the estimated amount of income, if any, you expect to be generated from this project that you wish to designate as match (equal to the amount shown for Item 15(f) on Form 424). **Note:** Any program income indicated at the bottom of Section B and for item 15(f) on the face sheet of Form 424 will be included as part of non-federal match and will be subject to the rules for documenting completion of this pledge. If program income is expected, but is not needed to achieve matching funds, **do not** include that portion here or on Item 15(f) of the Form 424 face sheet. Any anticipated program income that will not be applied as recipient match should be described in the Level of Effort section of the Program Narrative.

Section C - Non-Federal Resources
Line 12: Enter the amounts of non-federal resources that will be used in carrying out the proposed project, by source (applicant; state; other) and enter the total amount in Column (e). Federal match is not required for this NOFO.

Section D - Forecasted Cash Needs - Not applicable.

Section E - Budget Estimate of Federal Funds Needed for Balance of the Project

Line 20: Section E is relevant for multi-year grant applications, where the project period is 24 months or longer. This section does not apply to grant awards where the project period is less than 17 months.

Section F - Other Budget Information

Line 22 - Indirect Charges: Enter the type of indirect rate (provisional, predetermined, final or fixed) to be in effect during the funding period, the base to which the rate is applied, and the total indirect costs. Include a copy of your current Indirect Cost Rate Agreement.

Line 23 - Remarks: Provide any other comments deemed necessary.

c. Standard Form 424B - Assurances
This form contains assurances required of applicants under the discretionary funds programs administered by the Assistant Secretary for Preparedness and Response. Please note that a duly authorized representative of the applicant organization must certify that the organization is in compliance with these assurances.

d. Certification Regarding Lobbying
This form contains certifications that are required of the applicant organization regarding lobbying. Please note that a duly authorized representative of the applicant organization must attest to the applicant's compliance with these certifications.

Proof of Non-Profit Status
Non-profit applicants must submit proof of non-profit status. Any of the following constitutes acceptable proof of such status:

- A copy of a currently valid IRS tax exemption certificate.
- A statement from a state taxing body, State Attorney General, or other appropriate state official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals.
- A certified copy of the organization's certificate of incorporation or similar document that clearly establishes non-profit status.

Indirect Cost Agreement
Applicants that have included indirect costs in their budgets must include a copy of the current indirect cost rate agreement approved by the HHS or another Federal agency. This is optional for applicants that have not included indirect costs in their budgets.

Attachment B: Budget Narrative/Justification – Sample Format

The budget summary is used to determine reasonableness and allowability of costs for the project. All of the proposed costs listed must be reasonable, necessary to accomplish project objectives, allowable in accordance with applicable federal cost principles, auditable, and incurred during the budget period.

An allowable project cost meets the following criteria:

- Necessary for the performance of the award.
- Allocable to the project.
- In conformance with any limitations or exclusions set forth in the federal cost principles applicable to the organization incurring the cost.
- Consistent with the recipient's regulations, policies, and procedures which are applied uniformly to both Federally-supported and other activities of the organization.
- Accorded consistent treatment as a direct or indirect cost.
- Determined in accordance with generally accepted accounting principles.
- Not included as a cost in any other Federally-supported award.

The following four tests are used in determining the allowability of costs:

- **Reasonableness (including necessity)**. A cost is reasonable if it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The cost principles elaborate on this concept and address considerations such as whether the cost is of a type generally necessary for the organization's operations or the grant's performance, whether the recipient complied with its established organizational policies in incurring the cost or charge, and whether the individuals responsible for the expenditure acted with due prudence in carrying out their responsibilities to the federal government and the public at large, as well as to their organization.

- **Allocability.** A cost is allocable to a specific grant, function, department, or other component, known as a cost objective, if the goods or services involved are chargeable or assignable to that cost objective in accordance with the relative benefits received or other equitable relationship. A cost is allocable if it is incurred solely to advance work under the grant; it benefits both the grant and other work of the organization, including other grant-supported projects or programs; or it is necessary to the overall operation of the organization and is deemed to be assignable, at least in part, to the grant.

- **Consistency.** Recipients must be consistent in assigning costs to cost objectives. Regulations regarding cost assignment must be consistent for all work of the organization under similar circumstances, regardless of the source of funding, to avoid duplicate charges.

- **Conformance.** Conformance with limitations and exclusions contained in the Terms and Conditions of award, including those in the cost principles, may vary by the type of activity, the type of recipient, and other characteristics of individual awards.

Budget Summary

Section A – Personnel: An employee of the applying agency whose work is tied to the application. Proposed salaries must be reasonable. Compensation paid for employees must be reasonable and consistent with that paid for similar work within the applicant's organization and similar positions in the industry.

Table 1: Personnel

Position	Name	Annual Salary/Rate	Level of Effort	Federal Cost	Match
Project Director	Susan Jones	$45,000/year	100%	$45,000	
Project Coordinator	Brad Smith	$42,000/year	50%	$21,000	
			TOTAL	$66,000	

NARRATIVE JUSTIFICATION: Enter a description of the personnel funds requested and how their use will support the purpose and goals of this proposal. Describe the role, responsibilities, and unique qualifications of each position.

B. Fringe Benefits - Fringe benefits may include contributions for items such as social security, employee insurance, and pension plans. Only those benefits not included in an organization's indirect cost pool may be shown as direct costs. If fringe benefits are not computed as a percentage of salary (e.g. 25%), list all components of the fringe benefits rate, for example:

Table 2: Fringe Benefits

Component	Rate	Wage	Federal Cost	Match
FICA	7.65%	66,000	$5,049	
Insurance	5%	66,000	$3,300	
		TOTAL	$8,349	

NARRATIVE JUSTIFICATION: Enter a description of the fringe funds requested and how the rate was determined.

C. Travel - Federal funds requested for travel are for staff travel only (travel for consultants is listed in consultant category). Travel for other participants, committee members, etc. should be listed under the cost category "other". Applicants are to use the lowest available commercial fares for coach or equivalent accommodations. Note that Applicants will be expected to follow federal travel policies found at https://www.gsa.gov.

Table 3: Travel

Purpose of Travel	Location	Item	Rate	Federal Cost	Match
Attend recipient meeting	Washington, DC	Air Fare Per Diem Airport Parking Airport Shuttle Hotel	$350 X 4 people $71/day X 4 days X 4 people $10/day X 4 days $28/RT X 4 people $211/night X 3 nights X 4 people **Subtotal**	$1,400 $1,136 $40 $112 $2532 **$4,120**	
Local travel	Various	POV	.44/mile X 2,000 miles/year	$880	
			TOTAL	$5,000	

NARRATIVE JUSTIFICATION: Explain the purpose for all travel and how costs were determined. List any required travel, funds for local travel that are needed to attend local meetings, project activities, and training events. Local travel rate should be based on agency's personally owned vehicle (POV) reimbursement rate, which should correspond with the GSA rate found at https://www.gsa.gov.

D. Equipment - Permanent equipment is defined as tangible nonexpendable personal property having a useful life of more than one year and an acquisition cost of $5,000 or more. If the applying agency defines "equipment" at a different rate, then follow the applying agency's policy. In the case of vehicles, etc. applicant should justify purchase rather than rental. If equipment is used by several different projects, you may only charge a percentage of the costs for the purchase based on the amount of time, etc. that the equipment will be used for this grant program. Any purchased equipment must be inventoried according to the guidelines in the HHS Grants Policy Statement.

Table 4: Equipment

Item(s)	Rate	Federal Cost	Match
Computer Work Station	$5,500 X 2	$11,000	
Computer	$6,000 X .5FTE	$3,000	
	TOTAL	$ 14,000	

NARRATIVE JUSTIFICATION: Enter a description of the equipment and how its purchase will support the purpose and goals of this proposal.

E. Supplies - Materials costing less than $5,000 per unit and often having one-time use, for example – general office supplies, postage, printers, etc.

Table 5: Supplies

Item(s)	Rate	Federal Cost	Match
General Office Supplies	$50/month X 4 FTE	$200	
	TOTAL	$200	

NARRATIVE JUSTIFICATION: Enter a description of the supplies requested and how their purchase will support the purpose and goals of this proposal. Rates for office supplies, etc. may be based on average monthly costs, FTE, etc.

F. Contracts and Consultants - An arrangement to carry out a portion of the programmatic effort by a third-party or for the acquisition of goods or services is allowed under the grant. Such arrangements may be in the form of sub awards (grants) or contracts. A consultant is a non-employee retained to provide advice and expertise in a specific program area for a fee. List each contract, consultant or sub award separately and provide an itemization of the costs. If a contractor is to be determined, provide a best estimate as to costs for the goods or services to be purchased.

The recipient must establish written procurement policies and procedures that are consistently applied. All procurement transactions are required to be conducted in a manner to provide to the maximum extent practical, open and free competition. The recipient should be alert to organizational conflicts of interest as well as to noncompetitive practices among contractors that may restrict or eliminate competition or otherwise restrain trade.

Method of Selection: This will be sole source, competition, or grant.

Scope of Work: Provide a breakout of the goods and/or services being provided by the contractor. If personnel are being charged then should list name, position, hours and rate/hour. Goods will be listed at number of units and cost/unit. List method to be used for subrecipient/subcontractors monitoring – site visit, semi-annual reports, etc. Documentation of monitoring should be kept with the contract/award file.

Table 6: Contract/Sub award

Activity	Name	Method of Selection	Scope of Work	Federal Cost	Match
Public Information	WMTV	Sole source	Paid Ads 12/month X $250/ad X 6 mo. Paid Ads 12/month X $250/ad X 6 mo. **Monitoring:** semi-annual report	$18,000	$18,000
Mobil Medical Assets	To Be Determined	Competition	Medical supply inventory ($1,600) Wheelchair bus conversions(6 X $37,000) **Monitoring:**	$223,600	

Activity	Name	Method of Selection	Scope of Work	Federal Cost	Match
			semi-annual report		
			TOTAL	$ 241,600	$18,000

NARRATIVE JUSTIFICATION: Provide information as to how the contracted services or goods will enhance the project goals and objectives. Provide sole source justification.

Table 7: Consultant

Organization	Name	Number of Days	Rates	Federal Cost	Match
Trepid	Jon Smith	20	$150/day Travel 4 trips X 1,204 (travel @ $475; lodging @ $175/night X 3; Per Diem @ $51 x4) = $4,816	$ 7,816	
			TOTAL	$ 7,816	

NARRATIVE JUSTIFICATION: Provide information as to how the consultant services or goods will enhance the project goals and objectives.

G. Other - Expenses not covered in any of the previous budget categories. If rent is requested (direct or indirect), provide the name of the owner(s) of the space/facility. If anyone related to the project owns the building which is less than an arm's length arrangement, provide cost of ownership/use allowance calculations.

Table 8: Other

Item	Rate	Federal Cost	Match
Postage	$65/mo. X 4 FTE	$3,120	
	TOTAL	$3,120	

NARRATIVE JUSTIFICATION: Explain the need for each item and how it will support the purpose and goals of this proposal. Break down costs into cost/unit (cost/square foot or cost/month or cost/FTE).

H. Indirect Costs:

Also known as "facilities and administrative costs", indirect costs are costs that cannot be specifically identified with a particular project, program, or activity, but are necessary to the operation of the organization (e.g., overhead). Facilities operation and maintenance costs, depreciation, and administrative expenses are examples of costs that are usually treated as indirect costs. The organization must not include costs associated with its indirect rate as direct costs. If indirect costs are claimed, applicant is to submit a copy of a current negotiated indirect cost rate agreement. Indirect costs are only charged on the items cited in the indirect cost rate

agreement (e.g. personnel and fringe, subawards/subcontracts over $25,000).

Table 9: Indirect costs

Total Direct Cost applied to Indirect Cost	Indirect Cost Rate	Federal Cost	Match
$450,000	22%	$99,000	
	TOTAL	$99,000	

Attachment C: Project Work Plan and Timeline

Capability 1. Build a Partnership for Disaster Health Response				TIMELINE (MONTH)											
Activity	**Task**	**Lead Person/ Organization**	**Budget**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Objective 1. Establish and Build a Partnership for Disaster Health Response															
1. Identify Partnership members	MOAs / MOUs of required members														
	LOS of supporting organizations														
	Describe and LOS from additional partners														
	Identify operational barriers														
	Prioritize relationships with health equity organizations														
2. Propose and implement a governance structure	Include roles and responsibilities														
	Designate Executive Director and Medical Director														
	Integrate with existing incident management structures														
	Convene quarterly														
	Document governance leading practices														
3. Identify and build mechanisms to partner with other states in region	Describe established relationships														
	Identify mechanisms for regional planning														
	Documents challenges														

Capability 2. Align Plans, Policies, Processes, and Procedures				TIMELINE (MONTH)											
Activity	**Task**	**Lead Person/ Organization**	**Budget**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Objective 1. Identify and Address Critical Capabilities and Gaps in Existing Disaster Plans															
1. Assess statewide risk and vulnerabilities	Partnership involvement in state and local disaster planning														
	Trauma systems involved in state planning														
	Determine clinical impact of likely scenarios														
	Document statewide health care resources														
2. Identify and document planning gaps	Document planning gaps for statewide surge capacity														
	Document surge capacity assets														
	Conduct needs assessment for alternate care system														
	Define indicators and triggers														
	Identify barriers and gaps related to crisis standards of care strategy														
	Implement plan for crisis care														
Objective 2. Align Existing Coalition and State Response Plans to Facilitate Coordinated Medical Surge															
	Align protocols, policies, and														

1. Build a framework for coordination of patient management	procedures across coalitions														
	Identify and resolve planning conflicts														
Objective 3. Facilitate Legal and Policy Coordination and Alignment															
1. Identify laws, regulations and policies that may impact health care coordination in disasters	Document state processes for emergency declarations, waivers, liability protection, and asset allocation														
	Document legalities related to alternate care systems														
	Document laws, regulations, and policies impacting inter-state coordination of health care assets														
2. Establish real-time discussion mechanism	Demonstrate process for joint clinical policy development														
Capability 3. Increase Statewide and Regional Medical Surge Capacity				**TIMELINE (MONTH)**											
Activity	**Task**	**Lead Person/ Organization**	**Budget**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Objective 1. Train and Prepare Health Care and Medical Workforce															
1. Train on preparedness and response gaps	Identify basic elements in a standardized training program														
	Conduct a gap analysis														
	Use JIT														
2. Develop clinical expertise	Provide surge management expertise in chemical														

	Provide surge management expertise in radiation														
	Provide surge management expertise in burn														
	Provide surge management expertise in trauma														
	Provide surge management expertise in infectious disease														
	Provide surge management expertise in pediatrics														
	Assess needs and provide support for behavioral health														
	Identify methods to disseminate existing response expertise														
	Conduct statewide MCM analysis														
Objective 2. Identify and Utilize Health Care Surge Professionals															
1. Plan for the use of health care surge professionals	Develop a model and plan for specialized medical teams														
	Ensure highly specialized capabilities available														
	Plan for use of health care volunteers														
	Implement mechanisms that enable use of health care														

	professionals from other states														
	Develop a model and plan for MRC and ESAR-VHP volunteers														
	Plan for use of unaffiliated health care providers														
	Knowledge of interstate medical resources and personnel														
	Plan for addressing workforce resilience and behavioral health needs														
Objective 3. Increase Readiness for Medical Surge															
1. Improve inpatient, hospital, and EMS surge response	Policies and procedures to see surge capacity														
	Promote implementation of surge capacity planning in seasonal ED overcrowding														
	Document challenges														
2. Improve out-of-hospital surge response	Assure local coordination of acute care capabilities														
	Coordinate EMS response and patient movement choices														
	Document challenges														
3. Develop virtual support system	Describe use of telephone/telemedicine														

	Provide direction and oversight of pediatric and adult critical care														
Objective 4. Plan for and Coordinate Health Care Evacuation and Relocation															
1. Identify shortcomings in plans	Identify and address shortcomings in patient evacuation and relocation plans														
	Establish MOUs among health care and EMS														
2. Describe process for patient transport and tracking	Describe patient tracking and transport mechanisms														
	Describe process for family notification and reunification														
Objective 5. Maintain Access to Supplies and Equipment during an Emergency															
1. Assess supply chain integrity	Assess potential impact to supply chain														
2. Assess and address equipment, supply, and pharmaceuticals	Establish communications and MOUs for disposable DME, disposable supplies, medical gases, PPE, blood, pharmaceuticals.														
Capability 4. Improve Statewide and Regional Situational Awareness				**TIMELINE (MONTH)**											
Activity	**Task**	**Lead Person/ Organization**	**Budget**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Objective 1. Utilize Information Sharing Procedures and Platforms															
1. Coordinate health care situational awareness	Use central medical operations center														
	Identify roles of partners in medical operations center														

	Develop EEIs (clinical)														
	Develop EEIs (patient tracking)														
	Develop EEIs (health care situational awareness and decision-making)														
	Develop roadmap for IT														
2. Data protection	Establish data protection procedures														
3. Use information sharing systems	Establish common operating picture and describe its design and challenges														
	Develop processes and procedures for clinical knowledge sharing														
Capability 5. Develop Readiness Metrics and Conduct an Exercise				**TIMELINE (MONTH)**											
Activity	**Task**	**Lead Person/ Organization**	**Budget**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Objective 1. Test and Refine Existing Readiness Metrics. Developing Additional Metrics as Needed															
1. Test, develop, and implement metrics	Develop metrics for capabilities 2-4														
	Develop a capability and capacity analysis template														
Objective 2. Conduct and Exercise to Test Medical Surge and Situational Awareness Capabilities															
1. Conduct an exercise	Test and evaluate majority of capabilities 2-4														
	Include recognition, use of medical operations center, and clinical expertise														

	Test alternate care sites and conventional care delivery														
	Use the readiness standards and capacity and capability analysis														
	Conduct an after action review														
	Conduct a corrective action plan														

Attachment D: Evaluation and Performance Measurement Plan

Sample Guidelines

ASPR does not require a specific format for the Evaluation and Performance Measurement Plan, but suggests that this plan provide detail on the following:

Recipient Name: Insert Recipient Name

POC for Data and Evaluation: Insert Name and Contact Information

Evaluation

- The types of evaluations to be conducted (e.g., process or outcome evaluations).
- The frequency that evaluations will be conducted.
- How evaluation reports will be published on a publicly available website.
- How evaluation findings will be used to ensure continuous quality and program improvement.
- How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).
- Dissemination channels and audiences.

Performance Measurement

- Performance measures and targets (see NOFO section Reporting Requirements/Performance Measures).
- The frequency that performance data are to be collected.
- How performance data will be reported.
- How quality of performance data will be assured.
- How performance measurement will yield findings to demonstrate progress towards achieving
- NOFO goals (e.g., reaching target populations or achieving expected outcomes).
- Dissemination channels and audiences.
- Other information requested as determined by the ASPR program.

Attachment E: Quarterly and End-of-Year Report

Sample Template

TITLE PAGE

Application Title: (Title used in application package)

Report Type: (Quarterly report, End of Year Report, etc.)

Report Date: (insert date)

FOA Title: *Partnership for Disaster Health Response Cooperative Agreement*

CFDA Number: 93.817

This document was approved by:

Executive Director: (Printed Name & Signature)

Medical Director: (Printed Name & Signature)

State Public Health Department: (Printed Name & Signature)

SUMMARY PAGE

Description of Activities in the Reporting Period: (insert a summary of the activities that have been undertaken during this reporting period; highlight any challenges or barriers to adhering to the timeline or completing activities and tasks as required in the FOA)

PROGRESS REPORT

Detailed Progress Report on Activities and Tasks in the Work Plan: (refer to the work plan template, Attachment C, and provide an update on whether the activities and tasks are on schedule; provide an explanation for any activity or task that is delayed; indicate which activities and tasks are completed and include as attachments any supporting documents to demonstrate completion or success of the deliverable; indicate whether there have been any changes to the lead personnel assigned to activities and tasks)

PERFORMANCE MEASURES

For Mid-Year and End of Year Reports Only.

(Include a detailed explanation of progress toward meeting the performance measures included in this FOA and include as attachments any documentation that substantiates the answers to these measures (site visits, surveys, exercises, etc.).

RECORD OF FUNDS EXPENDITURE

Detailed Record of Funds Expenditure: (follow the budget narrative/justification format, Attachment B, to describe expenditures in the reporting period, including the purpose for which funds were spent, the recipients of the funds, and whether there are any deviations from the budget narrative projections.

Attachment F: After Action Report for Exercise

Sample Template

TITLE PAGE

Draft After-Action Report: (Insert Event Title)

Event Date: (Insert Date of Event)
Final AAR Release: (Insert Date of Final draft)
AAR Prepared By: (Insert Names and Contact Information)

CONTENTS

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

(Include a high-level summary of the event including where it was located, what facilities and personnel were involved, what capabilities it aimed to test.)

MAJOR STRENGTHS

The major strengths identified during the response are as follows:

(Insert strengths here.)

PRIMARY AREAS FOR IMPROVEMENT

(Insert areas for improvement here.)

CONCLUSION

(Insert conclusion here.)

SECTION 1: RESPONSE OVERVIEW

RESPONSE OVERVIEW

(Insert a detailed description of the event, including where it was located, what facilities and personnel were involved, what capabilities it aimed to test.)

TIMELINE OF EVENTS

Figure 1.1 and Figure 1.2 highlight some of the key response events during (Insert Organization and Partnership name) support to the (Insert event name).

Figure 1.1 Timeline of Response Events, (INSERT DATE)

(INSERT FIRST TIMELINE GRAPHIC HERE)

Figure 1.2 Timeline of Response Events, (INSERT DATE)

(INSERT SECOND TIMELINE GRAPHIC HERE

SECTION 2: ANALYSIS OF RESPONSE

About This After-Action Report

This After-Action Report (AAR) is to document operations in support of the (Insert event name) and to identify strengths and areas for improvement. The intent of this document is to provide information and recommendations to support and improve future responses. Issues identified in this report will help inform the initial improvement plan and begin the corrective action process. This report was completed by (Insert Names/Organizations).

The AAR Team employed the following approach in developing this AAR:

- **Observation: (**INSERT OBSERVATION DETAILS)

- **Data Collection and Follow-Up Interviews: (**INSERT DATA COLLECTIONAND INTERVIEW DETAILS)

- **Draft After-Action Report:** (INSERT NOTES ON AAR DATA SOURCES AND COMPILATION)

Assessment Framework

HHS designated the NHSS as a framework to guide efforts to enhance "preparedness and response capabilities to address the realities of our immediate and future threat landscape" and to minimize health consequences associated with significant health incidents.[25] The NHSS defines the goals, strategic objectives and operational capabilities under which national health security can be achieved. Implicit to this approach is the acknowledgment that this effort must be collaborative. Not only must there be active coordination among domestic stakeholders, but the Nation must also acknowledge its global interdependence in the world health community.

The 2019-2022 NHSS focuses on three overarching objectives: 1) to prepare, mobilize, and coordinate the United States government to bring federal medical and public health capabilities to support state, tribal, territorial, and local authorities during a health emergency; 2) to protect the nation from health effects of 21st century threats, including pandemic infectious diseases and chemical, biological, radiological, and nuclear (CBRN) threats; and 3) to leverage the capabilities of the private sector in preparing and responding to large scale health emergencies and disasters[26]. Operationalization of the objectives involves (INSERT # OF CAPABILITIES) specific capabilities grouped under (INSERT # OF ISSUE AREAS) issue areas.

[23] U.S. Department of Health and Human Services, *National Health Security Strategy, 2019-2022*
[24] Ibid.

The NHSS is not purely an incident response framework; it is an overall strategy for improving and maintaining the health status of the general population. This necessitates a customized application of the NHSS to response scenarios.

Analysis of Operational Capabilities

This section of the report reviews the performance of operational capabilities according to the issue areas presented in the NHSS and the NHSS Interim Implementation Guide. Observations are identified as either strengths or areas for improvement and are intended to inform planning for future HHS response activities abroad. This section is organized according to the following issue areas of capabilities as defined by the NHSS:

(INSERT ANALYSIS OF OPERATIONAL CAPABILITIES)

(INSERT ISSUE AREAS AND CAPABILITIES)

(USE THE TABLE TO PROVIDE ADDITIONAL DETAIL)

#	Deficiency Description	Actions to be taken (Prospective & Preventative)	Indicator the Deficiency is Resolved	Status Tracking and Reporting	Resources	Lead	Planned Complete Date	Actual Complete Date	Completion Confirmed Review Date

SECTION 3: CONCLUSION

(INSERT CONCLUSION)

AAR Appendix A: Acronyms

Acronym	Meaning
AAC	After-Action Conference
AAR	After-Action Report
ACF	Administration for Children and Families
ASPA	Office of the Assistant Secretary for Public Affairs
ASPR	Office of the Assistant Secretary for Preparedness and Response
CAC	Common Access Card
CDC	Centers for Disease Control and Prevention
CDC EOC	Centers for Disease Control and Prevention Emergency Operations Center
CMO	Chief Medical Officer
CONOPS	Concept of Operations
CONUS	Continental United States
DART	Disaster Assistance Response Team
DEA	Drug Enforcement Agency
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DoD	Department of Defense
DOS	Department of State
DPMU	Disaster Portable Morgue Unit
EEAA	Exercises, Evaluations, & After Actions
EHR	Electronic Health Records
EMG	Emergency Management Group
EMR	Electronic Medical Records
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF#6	Emergency Support Function Number Six
ESF#8	Emergency Support Function Number Eight
FACT	Family Assistance Center Team
FedEx	Federal Express
FEMA	Federal Emergency Management Agency
FMS	Federal Medical Station
FOUO	For Official Use Only
FY	Fiscal Year
GOH	Government of Haiti
HASP	Health and Safety Plan
HHS	United States Department of Health and Human Services
HSEEP	Homeland Security Exercise and Evaluation Program
IAP	Incident Action Plan
ICD-9	International Statistical Classification of Diseases
ICS	Incident Command System
IERF	International Emergency Response Framework
IHR	International Health Regulations
IMSURT	International Medical Surgical Response Team
INGO	International Non-Governmental Organization
IRCT	Incident Response Coordination Team
IRCT-A	Incident Response Coordination Team - Advance
JFO	Joint Field Office

Acronym	Meaning
JIT	Just-in-Time
JPATS	Joint Patient Assessment and Tracking System
JTF	Joint Task Force
LNO	Liaison Officer
LRAT	Logistics Response Assistance Team
MEDRETE	Medical Readiness Training Exercise
MOCC	Medical Operations Coordination Cell
MOU	Memorandum of Understanding
MC	Mobilization Center
MRC	Medical Reserve Corps
MRE	Meal Ready to Eat
NDMS	National Disaster Medical System
NHSS	National Health Security Strategy
NIMS	National Incident Management System
NRF	National Response Framework
OCONUS	Outside the Continental United States
OFDA	Office of United States Foreign Disaster Assistance
OFRD	Office of Force Readiness Deployment
OPEO	Office of Preparedness and Emergency Operations
OS	Office of the Secretary
OSHA	Occupational Safety and Health Organization
PAHO	Pan-American Health Organization
POC	Point of Contact
PPE	Personal Protection Equipment
RFPC	Responder Force Preparedness Center
RMS	Resource Management System
RMT	Response Management Team
RNA	Rapid Needs Assessment
SOC	Secretary's Operations Center
SOFR	Safety Officer
SOP	Standard Operating Procedure
TB	Tuberculosis
TRAC2ES	United States Transportation Command Regulating And Command and Control Evacuation System
TRANSCOM	United States Transportation Command
U.S.	United States
UN	United Nations
USACE	United States Army Corp of Engineers
USAID	United States Agency for International Development
USAR	Urban Search and Rescue
USG	United States Government
USNS	United States Naval Ship
USPHS	United States Public Health Service
VA	United States Department of Veterans Affairs
WebEOC	Web-based Emergency Operations Center software
WHO	World Health Organization

Table A.1: *Acronyms*

AAR Appendix B: Positive Feedback

This section includes individual positive comments submitted relating to the (INSERT EVENT NAME). These comments do not necessarily reflect the overall response.

AAR Appendix C: Recurring Issues

AAR Appendix D: Corrective Action Plan

(Use template provided in Attachment G)

Attachment G: Corrective Action Plan

Sample Template

Event Name here: Improvement Plan

	Observation	Discussion/Recommendation/Corrective Actions	Capability/ Agency/POC	Status Tracking	Notes:
Issue Area					
	Observation:	Discussion:	Capability:	Start Date:	
		Recommendation:	Responsible Agency:	Completion Date:	
		Corrective Actions:	POC:	Status:	
		Updates:			
	Observation:	Discussion:	Capability:	Start Date:	
		Recommendation:	Responsible Agency:	Completion Date:	
		Corrective Actions:	POC:	Status:	
		Updates:			
Issue Area					
	Observation:	Discussion:	Capability:	Start Date:	
		Recommendation:	Responsible Agency:	Completion Date:	
		Corrective Actions:	POC:	Status:	
		Updates:			

Attachment H: Table of Required Partners

Applicants must provide a table reflecting the names and affiliations of all required members in the partnership, using the template below.

Information for any additional (desired, not required) partners that have provided letters of support may also be included, but it is not required to do so.

Table of Required Partners					
Facility Name	Parent Organization	Address	Facility Classification	Facility Type	Facility has signed an MOU
	(Identify facility parent organization, e.g., Tenet, HCA, Kaiser, other, etc.)	*(Physical and mailing address)*	*(Classify the facility as public, private, non-profit, private non-profit, other, etc.)*	*(Identify facility as hospital, designated NDMS facility, trauma center, community health center, clinic, mental health facility, other, etc.)*	

Attachment I: Funding Priorities

A funding priority is defined as the favorable adjustment of combined review scores of individually approved applications when applications meet specified criteria. This adjustment shall be up to a total of 5 possible points, with points assigned as listed below. Eligibility for the adjustment will be determined by ASPR staff and will be based on information included in the additional letters of support from the desired partners (see table for full list of possible partners).

Using the table below, please clearly signify which, if any, letters of support in the Desired Letters of Support attachment should be taken into account when evaluating Funding Priorities and provide the page number for each relevant letter of support.

Desired Letter of Support Included		Entity	Page Number(s) Within Application
Deployable State Medical Teams [0.5 points]	☐		
State Office of Emergency Management [0.5 points]	☐		
State Children's Hospital Network (or equivalent) [.5 points]	☐		
Radiation Injury Treatment Network centers	☐		
Acute Care Hospitals/Medical Centers [0.5 points for each; up to 3 total points]	☐		
Acute Care Hospitals/Medical Centers [0.5 points for each; up to 3 total points]	☐		
Acute Care Hospitals/Medical Centers [0.5 points for each; up to 3 total points]	☐		
Acute Care Hospitals/Medical Centers [0.5 points for each; up to 3 total points]	☐		
Acute Care Hospitals/Medical Centers [0.5 points for each; up to 3 total points]	☐		
Acute Care Hospitals/Medical Centers [0.5 points for each; up to 3 total points]	☐		

Attachment J: Funding Preferences

To receive a funding preference, include a statement that you are eligible for a funding preference and identify and request the applicable preference using the table below to identify the page numbers for each piece of documentation enclosed with the application.

Statement of Eligibility: **The applicant, _____, is eligible for a funding preference based on the following qualification:**				
Qualification		**Documentation (must be enclosed or clearly signified as Funding Preference documentation in other components of the application)**		**Page Number(s) Within Application**
Qualification 1: Regional Coordination	☐	Letter of support from a majority or all of the health care coalition leaders (or point of contact (POC)	☐	
		Documentation to show the applicant has existing partnerships with these facilities by other means	☐	
Qualification 2: National Disaster Medical System	☐	Hospitals included in the partnership are clearly identified as NDMS participating facilities in the application	☐	
		Letters of support from NDMS participating facilities	☐	
Qualification 3: Degree of Risk	☐	State Joint Risk Assessment	☐	
Qualification 4: Significant Need	☐	Documentation of funds received by other federal sources, and narrative describing how these funds will be used to complement and/or leverage other preparedness funding for partnership activities	☐	